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RESOLVING CATASTROPHIC HEALTH PROBLEMS IN THE MEDICARE PROGRAM

HEARINGS

BEFORE THE

SUBCOMMITTEE ON GOVERNMENT EFFICIENCY,
FEDERALISM, AND THE DISTRICT OF COLUMBIA

OF THE

COMMITTEE ON
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

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RESOLVING CATASTROPHIC HEALTH PROBLEMS IN THE MEDICARE PROGRAM

THURSDAY, AUGUST 27, 1987

U.S. SENATE,
SUBCOMMITTEE ON GOVERNMENT EFFICIENCY,
FEDERALISM, AND THE DISTRICT OF COLUMBIA,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Nashville, TN.

The Subcommittee met, pursuant to notice, at 10:19 a.m., in room 16, Legislative Plaza, Nashville, TN, Hon. James R. Sasser, Chairman of the Subcommittee, presiding.

Present: Senator James Sasser.

Staff Present: Dr. John Callahan, Staff Director, John Wagster, Legislative Assistant, and Pat Harrison, Special Assistant.

OPENING STATEMENT OF SENATOR SASSER

Senator SASSER. Good morning. I want to welcome all of you here this morning. We are convening some field hearings this morning on the Subcommittee of Government Efficiency of the Government Affairs Committee, which I chair. I want to thank all of you that came here this morning to testify, and especially thank those who traveled long distances to be here today.

I'm going to have a rather lengthy opening statement this morning which I think is necessary to set the framework for the hearings that we are having here today. The hearings will focus on the tremendous burdens our senior citizens face in trying to pay for catastrophic health care. We will discuss ways to ease that burden. We will also discuss the quality of health care that our citizens are receiving.

As the population grows older here in the United States, Social Security and Medicare are having a greater and greater impact on the Federal budget. These two budget functions, Social Security and Medicare, currently account for more than $300 billion in Federal spending. That's nearly one-third of the Federal budget. Now, many will call our attention to that, but I will also call your attention to the fact that Medicare and Social Security, particularly, are virtually self-sustaining because of the funds they collect by way of the payroll tax for Social Security and Medicare. But having said that, these are enormous expenditures.

While these expenditures are great, they have only helped make old age livable. They have not solved what the noted geriatrician and Pulitzer Prize winner Dr. Robert Butler describes as "the tragedy of old age in America." The tragedy, of course, is that most elderly live in constant fear of financial ruin from a catastrophic illness.

Frankly, their fears are well-founded. Tragically, the threat of financial ruin from catastrophic illnesses will grow worse as our population ages.

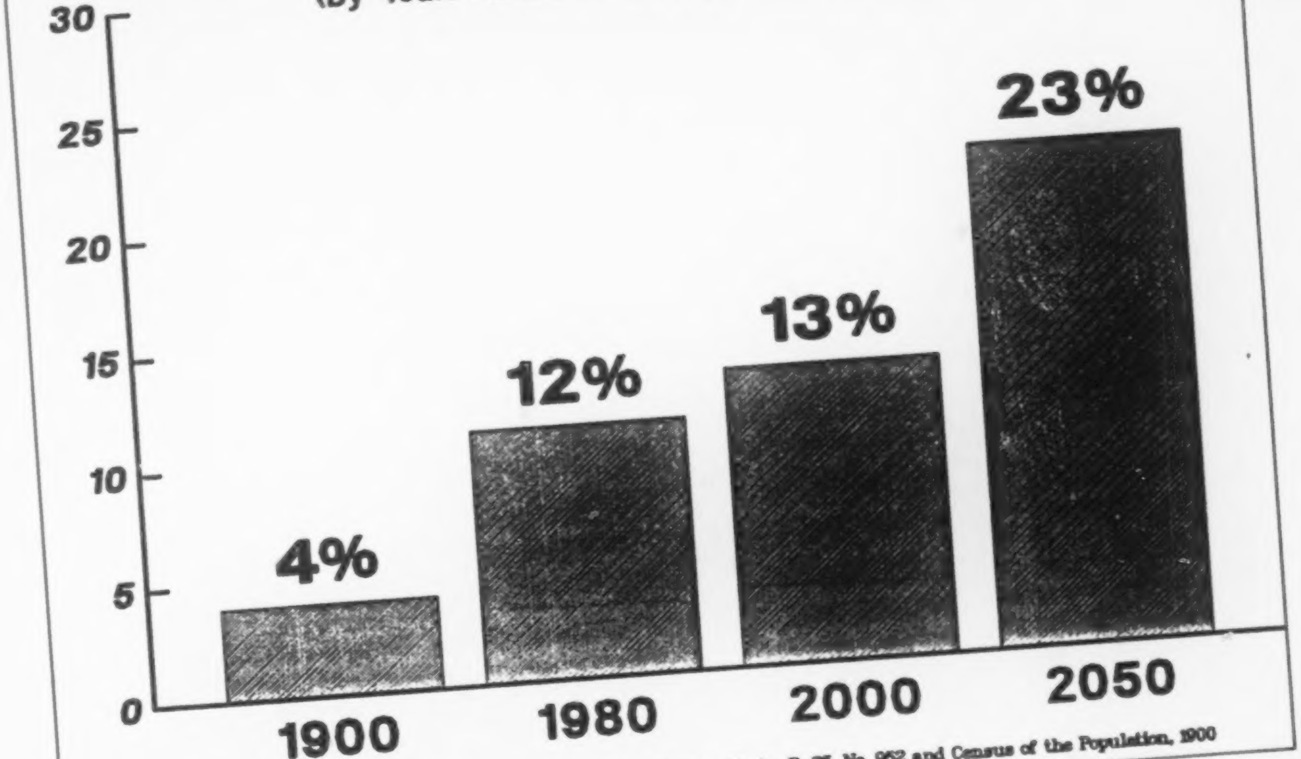
Over the past two decades, the number of Americans age 65 and older has grown twice as fast as the rest of the population, and the growth of the elderly will continue well into the next century.

Now, we have a chart here. As you can see from this chart—and Dr. Callahan will point it out there—the population 65 years and older will increase from 2.5 million in 1980 to 64.6 million in the year 2050. Nearly a quarter of all Americans will be over the age of 65 by 2050. There will also be an increase of almost 800 percent in the people that are 85 and older in our population by the year 2050. It will grow from 2.2 million people in 1980 who are 85 and older to 16 million who will be 85 and older by the year 2050.

[The chart referred to follows:]

Percent of Population Aged 65 and Over

(By Year: Actual and Projected Figures)



SOURCE: U.S. Bureau of the Census. Current Population Reports Series P–25, No. 952 and Census of the Population, 1900

Senator SASSER. We should be thankful that because of medical science and other reasons, we've now been able to live to such an advanced age. But this "graying of America" promises to greatly magnify the inadequacies in the current health care system, a system already drained by the heavy health demands of our elderly population.

The elderly are by far the heaviest users of health services. According to the National Center for Health Statistics, persons age 65 and older are hospitalized twice as often as younger people and they stay in the hospital, once they get there, twice as long. They also use twice as many prescription drugs.

It should come as no surprise that as one grows older, the likelihood of being stricken by a catastrophic illness that requires long-term care increases dramatically. The increase is most dramatic among the fastest growing segment of the elderly population, those whom are 85 years of age and older. In 1984, the National Center for Health Statistics reported that one in three Americans over age 85 required some form of intensive long-term care.

Yet the elderly currently have almost no options available to them to help pay for expensive long-term care. Most now quickly exhaust their own assets paying for nursing home care. It is no wonder, because the average cost of nursing home care runs about $22,000 a year. The Department of Health and Human Services reports that as many as one-half million elderly persons a year may have to exhaust their assets and have to spend down to the Medicaid limit while they are in nursing homes.

It is starkly evident that existing programs are falling far short of the mark in addressing these problems. Ninety-four percent or 94 cents out of every Medicaid dollar goes to pay for hospital costs and physician fees. Only 1 cent of every Medicare dollar goes to help the elderly pay the cost of nursing home care. Yet, a relatively large share of the elderly's out-of-pocket health care expenses—those are expenses that they have to pay themselves—42 percent—goes to covering the cost of nursing home care.

The painful truth is that there are currently great gaps in Medicare coverage, gaps which the elderly now have to fill with money out of their own pockets. This is a shocking statistic, but despite the Federal Government's efforts over the past 20 years, the direct out-of-pocket health costs for the elderly averaged 15 percent of their income in the year 1984—precisely the same amount as before the enactment of Medicare and Medicaid.

Partly out of frustration and partly out of fear, senior citizens are purchasing supplemental health insurance commonly referred to as "medigap policies." Many elderly believe that their supplemental medigap policies will pick up everything that Medicare does not. Yet, this is incorrect. Most of these so-called medigap policies cover none of the cost of nursing home care. Thus, they do not fill the largest hole left by Medicare.

Unhappily, the elderly often find themselves victims of unscrupulous medigap salesmen who play on the elderly's fear of catastrophic illness to convince them to buy one or sometimes several unneeded medigap policies. I've heard of cases where individuals were paying literally over $1,000 a month for multiple medigap policies that duplicated coverage they already had. There was an excellent piece on one of the local television stations here in Nashville that did a wonderful job of outlining that problem some weeks ago.

Fortunately, both the Administration and Congress have come to grips with the fact that private insurance alone cannot handle the health care needs of the elderly. We are seeing action to offer protection to our senior citizens that helps preserve them from the financial ravages of their health care needs. For example, earlier this year Dr. Otis Bowen, Secretary of the Department of Health and Human Services, issued a report on catastrophic illness expenses. This report served as a blueprint for legislation which passed the House earlier this summer. And when the Senate returns to session in September, we will quickly take up a bill very similar to the House-passed measure. I look forward to some of the comments today from witnesses regarding the bill that's now pending in the Senate.

I am pleased to be seeing some movement on this issue. A great Chinese philosopher said years ago, "A journey of 1,000 miles begins with the first step." This indeed is just the first step. Yet, frankly, I am greatly disappointed that neither the House bill nor the Senate bill adequately addresses the elderly's most common catastrophic health care expense, and that is the expense of long-term care. This is a critical shortcoming which calls into question the effectiveness of these proposals.

I have introduced legislation that would address the problem of long-term care and many other types of catastrophic costs. The legislation which I have introduced would cover long-term and extended hospital stays as well as major common health care expenses of the elderly, such as routine physician visits, dental care, eye care and care for hearing aids and that sort of thing. While we've made a good start with this year's bill, we're going to have to continue efforts to address the issue of long-term care.

I think that such a restructuring must focus more on the study of geriatrics—that's medicine for the special needs of the aging. We've simply got to recognize that the elderly often suffer from a whole constellation of chronic and multi-dimensional illnesses, sometimes simultaneously, that are very difficult to treat. We must recognize the needs of specialists to deal with these sorts of medical problems of the elderly. We are well conditioned to children having pediatricians that service the particular medical needs of children. I submit that our older citizens need geriatricians to take care of their particular needs also.

There is presently a significant lack of geriatric training in the United States. For example, although 75 percent of American medical schools now offer elective courses in geriatrics, only 4 percent of the medical students take them. For advanced geriatric training the figures are even worse. For the current academic year, there are only three geriatricians and not a single geropsychiatrist in advanced training in the entire United States of America.

One reason the scarcity of geriatricians exists is because treatment of the elderly, unhappily, is not considered to be very glamorous in the medical community. One of the most satisfying rewards of being a physician is the ability to heal people, to make them feel better, but there are rarely any fast cures for the chronic ailments of the elderly. As a result, physicians tend to lose interest in their elderly patients early because the patients appear to be hopeless cases that simply cannot be given a quick fix.

If health care for our elderly is going to improve, we must train more physicians to deal with their special needs. What good is additional care for the elderly if that care is not quality care?

I have advanced legislation that will address this shortcoming. The legislation will establish national centers of excellence for geriatric training in this country. These centers will help train specialists dedicated to improving the quality of care that our senior citizens are receiving. I hope to address this issue during debate on the Senate's Catastrophic Health Care Bill. If I am successful in establishing national centers for excellence for geriatric training, I'm hopeful that one can be established right here in Nashville at Vanderbilt University Medical School.

The hearings that we're having today will help add to the record on the critical issues that we face. It's clear that we have a lot of work to do. Whether we're talking about catastrophic health care insurance costs or the lack of geriatric training across this country, these are issues that deserve prompt and thorough attention.

We must put behind us the days when elderly Americans had to spend themselves into poverty, had to sell their homes, had to sell their possessions to pay for adequate health care, and that's happening in this country right now today. We've got to move beyond a health care system which fails to recognize the special health care needs of older citizens. The witnesses that we hear from today will contribute to the achieving of that goal.

At this point I'd like to ask the witnesses on Panel I to please take their places here at the center table.

Our first panel witness will be Leroy Parrish. Mr. Parrish is from Greenbrier, Tennessee. I assume this is Mrs. Parrish with him. We're delighted to have both of you, Mr. and Mrs. Parrish. Please be seated.

They are accompanied by Margie Nichols of WSMV here in Nashville. Ms. Nichols has an interest in this whole problem and has produced a very splendid documentary on the particular health care needs of the elderly.

Mr. Parrish, we're going to hear from you first. I understand that you were a railroad employee and that you are covered by Medicare.

Mr. **Parrish**. That's right.

Senator **Sasser**. And you realized that Medicare was not going to cover all of your needs, so you went out in search of a Medicare supplemental policy that would cover the gaps left in your Medicare coverage. Now, just tell us a little bit about your search for coverage to fill in the gaps for Medicare. What did you find and what did you encounter?

TESTIMONY OF LEROY PARRISH, GREENBRIER, TN

Mr. **Parrish**. Well, first let me say that we have AARP coverage supplementary to Medicare and we found that that didn't fill the gap, so we set out to find some additional help. We sent for as many policies as we could possibly locate. In doing so, we had a lady to come to us and she told us that she had what we were looking for. In the course of this interview, I was skeptical of it being what she said it was. Nevertheless, we agreed at that time to take the policy. After we received the policy, I looked it over and was reasonably sure that we did not have the coverage that we had anticipated.

I took this policy and sent it to a daughter of ours in Atlanta to have her check it over. She is in the insurance business, not particularly in this line, but in the insurance business. She told us she had conferred with a gentleman who is well informed on insurance coverage, and he said it was not what it was represented to be.

I sent this policy back to the company with a request to refund our money. But instead of refunding our money as the policy so stated, they gave the policy back to the lady who came out for the interview. She called us and she wanted to come back and talk some more. I didn't want to be nasty to her so I told her it would be all right, and I agreed to let her come back and we made an appointment. When she came back, I still insisted that we were reasonably sure that it wasn't what she told us. After she left, I sent the policy back to the insurance company for the second time.

The insurance company then sent me the insurance policy back for the third time. At that time I got in touch with the Department of Insurance and he told me that he could give me some help as far as getting my money back on this policy.

Senator **Sasser**. Well, let me ask you this. This is the State Department of Insurance that assisted you in getting a refund?

Mr. **Parrish**. Yes, it was.

Senator **Sasser**. Well, I'm very pleased to hear that you received the type of assistance that you needed from the State Department of Insurance. That's very encouraging. I think they have been responsive to a number of requests similar to yours. Mr. Parrish, do you think that Medigap salesmen are misstating, in your view, the terms of the policy? Do you believe they are taking advantage of our older citizens in trying to sell these policies?

Mr. **Parrish**. I'm definitely sure that some are. I don't know the percentage. I do know from this experience and of experiences that we have heard of that they are doing that very thing.

Senator **Sasser**. Do you think that the majority of citizens are aware of the inefficiencies or inaccuracies in many of the Medigap policies, or are they operating under the theory that these Medigap policies actually fill in the gaps for them that Medicare doesn't cover?

Mr. **Parrish**. I feel that's true for a lot of citizens, particularly older citizens. When I speak of older citizens, I'm talking about people who may not have all their mental capacity. People come and present things that they make look better than what it really does, and on that the pretext of not wanting to depend on the government or anybody else to provide what they need citizens take it. In those instances they have agreed to take a policy even though the salesman knows at the time that it will not do what they're telling them.

Senator **Sasser**. The salesman sells the policy, even though the salesman at the time they sell it knows that the policy will not give the coverage that the salesman represents it will cover. Is that what you're telling us?

Mr. **Parrish**. That's exactly what I'm saying.

Senator **Sasser**. There have been allegations made in letters to my office and in conversations that I and my staff have had around the state with some of our older citizens that so-called scare tactics have been used with some of our elderly citizens in selling these Medigap policies. Do you have any information about that or have you had any experiences along that line?

Mr. **Parrish**. No, not really. I think that the people that come to talk to us realize that we have done some actuary work to find out what beforehand we were looking for. I realized from checking the first policy that I wasn't informed on these matters as I should be, and now I'm not sure that the policies I have are what I actually need.

Senator **Sasser**. Mr. Parrish, you appear to be a man who knows something about the business world. You are knowledgeable enough to read a policy, and if you don't fully understand it, at least seek some sort of expert advice as to what the policy does cover. Do you find in your experiences that many elderly people know what they're buying with regard to these medigap policies?

Mr. **Parrish**. I feel that a big percent of them do not know what they're buying.

Senator **Sasser**. Have you run across any cases where medigap insurance salesmen may have used coercive tactics in trying to get the elderly to buy policies?

Mr. **Parrish**. Personally, I have not.

Senator **Sasser**. Let me just ask you this. Do you think it's a good idea to expand Medicare so that these medigap policies are not needed?

Mr. **Parrish**. Yes, if the expansion would be within the bounds of the ability of people to pay.

Senator **Sasser**. That's the next question. In other words, I think we'll all agree that it would be fine to expand Medicare so that no supplemental insurance coverage was needed. We wouldn't need any so-called medigap policies. But the question comes, how do you pay for it? Now, in your view, would it be a good idea to expand Medicare coverage for supplementary insurance even if it meant that Medicare would cost a little more for the Medicare recipient?

Mr. **Parrish**. I definitely do. To verify that, we are presently paying approximately $200 a month, for 3 coverage, Medicare, a Medicare supplement and a supplement to a Medicare supplement.

Senator **Sasser**. So that's $1,200 a year that you're paying there for medical insurance coverage?

Mr. **Parrish**. $2,400.

Senator **Sasser**. $2,400. Well, I never did very well in arithmetic, and now you can see why. So that is for Medicare and Medicare supplements.

Mr. **Parrish**. Yes. That includes Medicare, a supplement to Medicare and a supplement to a supplement to Medicare.

Senator **Sasser**. The supplement and the supplement to the supplement, are those private policies?

Mr. **Parrish**. One of them is AARP and the other one—would you want me to call the name?

Senator **Sasser**. Well, not necessarily call the name, but what I wish you would do is separate out what you pay for Medicare from what you pay for additional supplementary coverage. You told us your total bill was $2,400.

Mr. **Parrish**. First, what is Medicare?

Senator **Sasser**. It's $18 and a few cents a month.

Mr. **Parrish**. Then we have a Medicare supplement, AARP, which is $40.90. We pay $71 plus a month. Plus we have $200 a year that Medicare doesn't pay. I believe that's correct, isn't it?

Senator **Sasser**. Yes, that's the deductible.

Mr. **Parrish**. Then on this AARP policy, I believe it's $75 a year. So it makes a total of $550 a year for two of us.

Senator **Sasser**. Would that be $550 a year times two?

Mr. **Parrish**. No, that's for both of us.

Senator **Sasser**. So would it be fair to say that after you pay your Medicare and your Medicare deductible, that that's going to be about—after that, your additional expenses would be in the neighborhood of $1,500-1,600? Is that fair?

Mr. **Parrish**. It would be somewhere close in that neighborhood, yes.

Senator **Sasser**. All right. So you're paying $1,500 or $1,600 for coverage over and above what you pay for Medicare and Medicare deductible?

Mr. **Parrish**. Yes, that's correct.

Senator **Sasser**. For you and Mrs. Parrish.

Mr. **Parrish**. Right.

Senator **Sasser**. Mr. Parrish, do you have anything else to add this morning that you think would be helpful to us.

Mr. **Parrish**. This catastrophic bill that we're talking about, I'm not familiar with it. However, it could be possible for the ones in our age group to pay as much as they can afford to pay, because I know that some are going to be able to pay more than others, but I don't know if it can be worked out to where people would pay what they are able to pay.

Senator **Sasser**. I think it is possible, Mr. Parrish, and so does Congressman Claude Pepper over on the House side. We have what we think is a very reasonable piece of legislation which will be very affordable for older citizens. As a matter of fact, under our coverage, for total and complete coverage, you'd probably be saving about $1,200 a year over what you are presently paying.

Mr. **Parrish**. That's mighty good news.

Senator **Sasser**. All we've got to do now is convince 51 senators and the majority of the House and the President, and we'll be in good shape. Thank you very much for your testimony this morning.

We now have Ms. Nichols from WSMV. Ms. Nichols, you have a statement for us this morning.

TESTIMONY OF MARGIE NICHOLS, NEWS REPORTER AND PRODUCER, WSMV-TV, NASHVILLE, TN

Ms. **Nichols**. Yes, sir. I'm here today to share with you some of the research that is the result of a series produced by WSMV on Medicare supplement insurance. Our focus was on the abuses and sale of this insurance which is commonly called medigap insurance.

I had the opportunity to talk with many senior citizens, including Mr. Parrish, about the problems they had with this insurance.

Their primary problem was the salesmen who come into their homes. Many of the elderly have a story to tell and they have sad stories to tell about unscrupulous salespersons whose major concern is to make a sale. I also reviewed numerous complaint files from the State Insurance Department, complaints from senior citizens who felt they had been treated unfairly by a salesperson. In addition to this, WSMV conducted its own investigation.

We used a hidden camera and we secretly videotaped sales presentations of these medigap salesmen. Three of the four people we taped used unfair tactics according to a consumer advocate for the State Department of Insurance. The tactics that we actually witnessed included scare tactics, high pressure and intimidation. In an effort to make a sale, agents went so far as to misrepresent their company's policies and others just out and out lied about their policies or about policies that other companies carry or that these citizens might have with another company.

Often the agents would come into an elderly person's home acting very nice, very charming and very flattering. But we witnessed them change very quickly when they weren't going to make a sale. We saw them shift gears and start using scare tactics and intimidation. Many senior citizens have told me that they felt like they actually had to buy a policy just to get these people out of their homes. They wouldn't leave. They'd sit there and put the pressure on continually. The senior citizen said, "We had to buy a policy just to get them out of our house." For example, one agent used this phrase: "You wouldn't have me drive all the way down here and not get this policy, would you?" But this was after the woman had told the agent she didn't want him to come to the house in the first place.

Another agent told an 86-year-old woman that her insurance company was going out of business. It frightened this woman so much that she immediately wrote out a check for $804, which was 2 months income for her, and gave it to the agent to buy his policy. The truth is her policy, a perfectly good policy, was active for six more months, and the company was not going out of business.

A 90-year old woman was forced to go on food stamps because a salesman who had been calling on her for many years all at once sold her well over $1,000 worth of insurance—medigap, cancer, medical indemnity policy—and she didn't even need the policy because her income was so low that she qualified for the State Medicaid program.

This same agent sold another woman over $2,000 worth of insurance. The woman had no running water in her house. She had no bathroom in her house. She also qualified for Medicaid. Complaints about this one agent go back to 1980 and he has a history of treating women, primarily women, this way.

Senior citizens are afraid of high health care costs. They're afraid of sticking their families with the bills. That's why these tactics work. One agent was literally stealing money from senior citizens. He'd go in their homes, and sell them a policy. He'd then have them make the policy out to a company that had initials. The initials just happened to be his own. He cashed the checks and pocketed the money. Of course, he had all the literature from the insurance company and he had a legitimate license to sell, so there was no reason for them to really question it until they ended up never getting a policy. This man was later arrested.

Two of the biggest problems that we discovered were agents who would say that their policies covered everything. They never would go into the exclusions and all of these policies had exclusions. Agents would run down another policy to sell their own. This is called twisting or rolling business. Even when senior citizens had a policy, they wanted them to change from their current policy to another policy. It becomes very confusing to the senior citizen and they don't know who's telling the truth.

The truth is these agents make 60 percent on a first-year commission. That's why they have such an incentive to continually sell policies. Many of the agents work for a number of different companies, so they'll sell a different policy every year from a different company. Or they move; there's a big turnover in this business and they move from one company to another. They go back to the same people all the time. They work for this company this year and they'll sell them a policy. They'll change companies and they sell them this policy. The problem for the senior citizen is that most of these policies have a six-month exclusion where anything you've ever had is not covered. So it leaves them with no coverage and it leaves the agent with a hefty commission.

One of the most outrageous things we saw—and this was on an actual video tape that we have—was an agent who went to a woman's home and saw that she was a very religious by the things that were in her home. He actually said to her: "God sent me here today, so there's a good reason I'm here, and you should buy this policy." So there are tremendous abuses they intimidate, they scare, they exploit the fears that the elderly already have about health care costs.

Senator SASSER. Ms. Nichols, thank you very much for your testimony. There are a few questions that I'd like to ask you this morning. Based upon your investigation, how widespread do you feel that these abuses are? Are we dealing here with abuses that are isolated to a very few people, that are isolated to a particular geographical area, or is it your opinion here this morning that these abuses are widespread both in terms of population and geographically?

Ms. NICHOLS. From my research, three of the four agents that we videotaped misrepresented. There was one agent that was fair and honest out of four. From the phone calls that I've received since this series ran, I believe that the misrepresentation is widespread. We found that primarily this is going on in rural communities. A lot of the companies are in the city, but they spread out because you have a less sophisticated audience. You have people that don't know where to go to complain. They don't know how to complain. You have more people living alone in isolation. I know of one company in particular that will take a group of agents, go to a small town, put the agents up in a hotel, and then they canvas the area. Their whole thing is to sell insurance for 1 week, 2 weeks at a time. Then they come back to the city, and then they'll go to another small town and just stay there and sell insurance.

Senator SASSER. And they start out with no leads; they just move into the area and go door-to-door?

Ms. NICHOLS. Go door-to-door. Now, sometimes they do have leads. There are a lot of lead cards and things like that. But a lot of it is going door-to-door, going unannounced. You're working with a very trusting element of society and there was a time when you could answer the door and let people into your home.

Senator SASSER. How can the elderly, in your view, avoid these problems with these insurance salesmen?—just not let them in the door, I suppose.

Ms. NICHOLS. I think education helps. Since the series ran, I've gotten calls from agents who said that people were asking a lot more questions. I think the more word we get out, the more they will realize that they don't have to put up with this. Another form of education is calling the Insurance Department. They do help. They have a toll-free number. We can tell them the Insurance Department is there to help them with these problems and to call them, that it's okay to call, okay to complain. They can get help from their children and involve other people.

Senator SASSER. Generally, what was the response you received after your documentary was shown on your television station from elderly people themselves, those who might be prospective purchasers of insurance and those who had purchased policies?

Ms. NICHOLS. It was positive. They were appreciative that we had done this, that we had taken the time to focus on a problem that they are having. I got a lot of calls from children, that it made them aware that they need to look into what insurance their parents have, what's happening to them. It educated them to the fact that they didn't have to put up with this, and that it's happening to a lot of people; it's not just them. It let them know that they do have the right to ask questions and to say: "Wait a minute. This is not the way that I understand it to be." It was a positive response.

Senator SASSER. I understand that there were a number of complaints to the Department of Insurance and the Department of Insurance, from what my information is doing an excellent job of trying to handle these complaints.

Ms. NICHOLS. They've done an excellent job of getting people's money back for them, but a problems still exists that many of these agents remain on the street, because sometimes it's hard to make a case against them. They do get the money back and that's important. But if this same agent goes on to abuse someone else who doesn't know how to complain, you still have a problem. It's hard to make a case against these people, it truly is, but the biggest problem we have is repeat offenders.

Senator SASSER. Now, what about the insurance companies themselves? There are reputable medigap companies.

Ms. NICHOLS. Yes.

Senator SASSER. And I assume there are reputable medigap salesmen.

Ms. NICHOLS. Yes, sir. Some of the policies that unscrupulous salesmen sell are fine policies. It's not the policies. It's the language that's used to sell the policies.

Senator SASSER. Misrepresentation as they sell the policy.

Ms. **Nichols**. Exactly. The policy is not necessarily a bad one. It's the exclusions, the limitations, what the agent does not tell the senior citizen when they don't tell them the truth when they're selling a policy. Many of their policies are very similar because they're mandated by law. There are certain things that they have to cover by law, so they're very similar. The policy is not the problem; it's the salesmen.

Senator **Sasser**. In your investigations, did you uncover any efforts on the part of the companies themselves to police their own salesmen?

Ms. **Nichols**. Some.

Senator **Sasser**. Some did, some didn't.

Ms. **Nichols**. There are a lot of people that don't like this kind of behavior. There were a lot of insurance companies, frankly, that were glad we did it, because it hurts the whole insurance industry to have people like this on the street that are being unfair.

Senator **Sasser**. But to date there has been, to your knowledge, no collective effort on behalf of the carriers themselves to try to police the industry in this regard?

Ms. **Nichols**. That's difficult to answer because of a lot of reasons. It's too detailed to go into.

Senator **Sasser**. Well, we may hear others about that before the day is over.

I want to thank you very much, Ms. Nichols, for your testimony here today. I think that the work that you did on the series was a fine public service in the highest traditions of journalism. I want to commend you for doing it. I'm hopeful that at some juncture we can get you to Washington to appear before a committee there that might be looking into this whole matter, say the Finance Committee helping us with some of the legislation, or at the very least if we could have access to some of the footage that you shot so that we could share that with some of our colleagues on other committees that are concerned about this whole problem. Thank you very much.

Thank you again, Mr. and Mrs. Parrish.

Now, we have a second panel of witnesses. That will consist of Mr. Lyle Reid, the distinguished Deputy Commissioner of Insurance here in Tennessee. Mr. Reid has served in the Tennessee House of Representatives. He has also served in the capacity of Assistant Attorney General and as a Judge. Commissioner Reid is a well-known practicing attorney with the long-standing firm of Reid and Banks of Brownsville, Tennessee. Most recently he has chosen to give his time and talent in public service as Deputy Commissioner of Insurance. Commissioner Reid, if you will come forward.

He will be joined by Mr. Robert Maxwell, the Vice-President of the American Association of Retired Persons, who is currently serving his 2-year term as Vice-President. Mr. Maxwell is a nationally recognized expert in the issues of the aging. He is a native of Crossville, Tennessee, up on the Cumberland Plateau, and he was previously employed as Director of Education for the Hartford Insurance Group until his retirement in 1977.

Our last panelist is Ms. Linda O'Neal of the Tennessee Association of Legal Services here in Nashville. Ms. O'Neal holds a Masters Degree in Public Administration. She also is a practicing lawyer. She is an experienced and competent attorney with the Legal Services with tremendous expertise in issues pertaining to elderly health and hiring and housing issues, and those are important issues.

First, I'd like to recognize Commissioner Reid and open the floor for any statement that he might wish to make and his comments.

TESTIMONY OF LYLE REID, DEPUTY COMMISSIONER, TENNESSEE DEPARTMENT OF COMMERCE AND INSURANCE

Commissioner Reid. Thank you, Senator Sasser. It certainly is a great privilege to appear before your Subcommittee and discuss a matter which is of great interest to our department.

My statements will be from the perspective of a State regulator rather than as an advocate of any particular policy. In view of the testimony which you have heard and the testimony which I understand will be presented, the main emphasis of my remarks will be some of the problems which we have noticed in undertaking to regulate this particular segment of the insurance industry.

As you know, the Department of Commerce and Insurance has the responsibility to regulate the insurance industry in the State of Tennessee, within the limits that are provided by law. There are some big problems which we have noticed in the short time that I've been with the Department with regard to Medicare and Medicare supplements. It seems that there are a few problems which have to do with the Part A benefits, but the major problems which we have encountered relate to the part B coverage.

Many senior citizens complain that Medicare's customary and reasonable charges do not keep pace with the actual doctors' charges and, therefore, there is this gap which continues to widen and is a problem for those elderly citizens. Another area of concern is no coverage for skilled nursing care. This is becoming a greater problem as time goes on.

With regard to insurance written to provide assistance to the elderly there are, as has been pointed out, some very fine companies which write insurance which is needed and which is helpful. There are companies which provide insurance at what appears to be a reasonable premiums. Unfortunately, there are abuses in this segment of the industry. Those have been dramatically and graphically described by Ms. Nichols in her testimony. She made her information available to the Department and the information that she developed is being used by the Department in an effort to see that the law is complied with by the people who are in this business.

Based on the complaints and the investigations we have seen, many of the people who are selling medigap policies are either not aware of what the provisions of their policy are or they intentionally misrepresent the coverage. Again, there are many well-respected, knowledgeable agents who do properly represent the terms of their coverage and who really are doing a legitimate, proper business. Unfortunately, there are others who are not so conscientious.

These are some of the main problems which we have seen over the last several months as I have become more acquainted with this aspect of our industry. I would be glad to respond to any specific questions that the Senator may have an interest in.

Senator SASSER. Thank you very much, Commissioner. Could you provide us here this morning with a general rendition of some of the complaints that the Department of Insurance receives from Tennessee elderly with regard to the so-called medigap policies.

Commissioner REID. I think perhaps the major one is the one that has been discussed by Ms. Nichols, that the salespeople, either because they don't know what the policies provide or perhaps intentionally, misrepresent the benefits. The policies which are sold in the state have to meet minimum coverage requirements, and the state also to some extent regulates the premiums. If you examine the policy, it will probably do what it says it will do. The problem occurs in the explanation of the benefits. This is probably the greatest single problem that we have.

We have a problem with an agent selling coverage which obviously is not needed. They sell a Medicare supplement to people who are entitled to Medicaid benefits. Of course, there doesn't seem to be any need for that.

There are all the problems implicit in a situation where you have a person who doesn't have access to or doesn't make use of the advice that may be available. Perhaps you wouldn't expect them to call the Department of Insurance but they should call their relatives, they should call somebody, go to the druggist, go to the doctor, go to the lawyer, go up to anybody on the street and say, "What do you think about this policy?" It's a matter, perhaps, of the parties not being evenly matched. This is a contract. Because of the particular situation of the elderly and perhaps because of the inclination of the salesperson, the parties are not evenly matched. Therefore, sometimes the result is not altogether fair.

Senator SASSER. Commissioner, does the Department have any estimates of how many of these medigap policies might be in effect in Tennessee at this juncture?

Commissioner REID. Senator, we have no estimate as to the total number of individual policies. I understand that there are somewhere between 50 and 100 companies, but there is not available in our records the total number of individual policies which are in effect at this time.

Senator SASSER. Do you have any sort of estimate or does the Department have any estimate of how many of the medigap policies are sold on a door-to-door basis or how many might be sold through the mail?

Commissioner REID. No, we don't. We know, of course, that some of the sales are made through television advertisements, some are sent out through the mail, and there are door-to-door sales. We do not have any information as to the percentages of the various means of sale.

Senator SASSER. Commissioner, it's my understanding under Federal and State law, the elderly have a 10-day look-in period during which time they can review the medigap policy. If its not satisfactory and if it's not as represented to them, they can return the policy and receive a return on the premium. Now, there is pending legislation in the Senate of the United States which would extend the look-in period up to 30 days. Would your department in your view favor such an extension?

Commissioner **Reid**. Well, I think that there would be no good reason not to have such a time within which the purchaser could review the policy and decide whether or not they really want to keep it. I don't think that the more responsible companies would have any objection to this extended period of time. What sometimes happens is that the purchaser of the policy buys it and perhaps they weren't totally sure that they wanted it or needed it at the time; and in the course of some time they'll start talking to their neighbors or their children, and it is difficult to accomplish all this within 10 days. So I think that some additional time would probably be helpful, and I don't think the more reputable companies would have any objection to that. This is obviously a personal opinion, as we have not made any inquiries.

Senator **Sasser**. One final question, Commissioner, and the staff has suggested that I ask you this question. Under current law and regulations, for medigap policies to be certified by the State they are required to have a 60 percent loss ratio, that is a 60 percent ratio between benefit payment to earned premiums. Yet I understand that some carriers such as Blue Cross and Blue Shield have reported loss ratios in the vicinity of 81 percent. What are the basic causes for such variations in loss ratios? Do you believe that there should be a higher than 60 percent of minimum loss ratio for medigap carriers?

Commissioner **Reid**. Of course, when we talk about loss ratio, the higher the loss ratio, all other things being equal, the more beneficial policies. The loss ratio per se indicates the percentage of the total premium dollars which are paid out in benefits. I don't know if it rises quite to the dignity of law—but the standard of 60 percent is considered to be a minimum which would be required. Different companies are organized differently. Blue Cross does not sell on commission, so their expense of selling is less. If you have a non-profit company, as some of these are, which do not pay a return to shareholders, then it would seem that perhaps they could have a high loss ratio.

I think in the insurance industry generally, 60 percent is fairly low. I think that's the situation. The 60 percent is a fairly low loss ratio in the insurance industry and it is, I think, reasonable for that to be considered perhaps the very lowest that would be acceptable.

Senator **Sasser**. Commissioner, the regulation of insurance companies and generally supervision of insurance companies have traditionally been left to the state governments. In the situation here of medical policies being sold very extensively through the mail and through national advertising, is there any suggestion that you might wish to make at this time as to how the federal government could be helpful to State governments in their efforts to regulate these health policies and more specifically medigap policies?

Commissioner **Reid**. Senator, people who are much more knowledgeable about this matter have considered this and it's not free from differences of opinion. I'm not prepared to address that. I would say that I think the attention which is being focused upon it, in a large measure due to your efforts and those of others, that it is a matter which needs to be considered. It needs to be understood, and there are some rather serious problems. So I think whatever the outcome, whatever specific legislation is adopted, the examination is very helpful. The fact that the news media will carry what you're doing here is helpful. I think a better understanding by all the people who are interested cannot but result in some improvement. It is a serious problem.

I couldn't add to the way that Ms. Nichols described it. There are some very difficult, unfortunate, truly sad situations that have occurred. Also, there are some companies that are doing a good job. I think we need to work our way though it and find out, as you are, what the best solution is.

Senator **Sasser**. Well, as this whole matter progresses, if you or others in your department see ways in which we can be helpful on the federal level in dealing with this problem, I would urge you to contact me or contact members of our staff. We have a vital interest in trying to rectify some of the problems, and I think you're closer to where the rubber meets the road here and you're the man getting the complaints. So if we can be helpful, I hope you'll advise us.

Commissioner **Reid**. Thank you very much.

Senator **Sasser**. We will turn now to Mr. Robert Maxwell, the vice-President of the American Association of Retired Persons for any statement that he might have. Mr. Maxwell.

TESTIMONY OF ROBERT MAXWELL, VICE PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. **Maxwell**. Thank you, Senator Sasser. On behalf of our some 26 million members, I want to thank you for the opportunity to bring our association's views on the three health care issues during this hearing that seem to us to be of critical importance to older Americans—that is catastrophic health care costs, the role of Medicare supplemental insurance to protect the elderly against high cost illness, and the need for adequate members of well-trained medical professionals to deal with these special health care needs.

Senator, I've submitted written testimony.[1] I'm going to try to brief this.

Senator **Sasser**. Your testimony will be carried in the record in toto. We appreciate your trying to be brief about it.

Mr. **Maxwell**. As an association, we certainly want to thank you personally, Senator Sasser, for your interest in developing a meaningful catastrophic illness protection plan for older Americans and your efforts to increase the numbers of well-trained geriatric specialists.

Undoubtedly, the most critical need for catastrophic protection for older Americans is for help with the costs of long-term care. Nursing home stays account for 80 percent of the expenses incurred by older people who experience very high out-of-pocket medical costs. An acute care illness is less likely than long-term illness to result in a catastrophic burden. Medicare's coverage of acute care is by no means complete. Beneficiaries must still pay deductibles and co-insurance for Medicare coverage services and they must bear the full weight of the cost of non-medicare coverage and services and products. All older Americans, of course except the very wealthy, are at risk for the catastrophic costs associated with long-term care, but even acute care illness can impose heavy burdens on the 20 percent of Medicare beneficiaries whose Medicare coverage is not supplemented by medigap or Medicaid.

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[1] See p. 131.

The Medicare Catastrophic Protection Act of 1987 passed by the full House last month represents a significant effort to improve Medicare's coverage of critical areas. It does expand Medicare's coverage of hospital, physician, home health care and skilled nursing facility services. It introduces a very important out-patient prescription drug benefit and a new respite benefit. Additionally, it addresses the problem of spousal impoverishment and provides special protection for low income elderly. However, we are particularly concerned about the failure of the bill to deal with the cost of long-term care. The bill also leaves the beneficiary at risk for about $2,000 worth of cost sharing for Medicare coverage services and for the unlimited costs associated with excess billing by physicians; dental, vision, hearing care; physical examinations; and pap smear tests.

Legislation with similar benefits, the Senate bill soon to be debated, lacks several of the important benefits that are present in the House bill. The Senate bill does not have coverage for out-patient prescription drug costs. It does not really provide adequate protection for low income elderly. It does not provide protection against spousal impoverishment.

Both the House-passed bill and the Senate proposal will require Medicare enrollees to pay the entire cost of new benefits. Both versions would impose on enrollees two new catastrophic premiums—a basic premium to be paid by all enrollees and an income-related payment to be made by about 40 percent of enrollees. Both premiums are in addition to the current law, Part B premiums.

Our association urged passage of the House bill, but we continue to be concerned about the financing mechanisms. For the very first time, beneficiaries are being asked to bear the entire cost of expanded benefits. The elderly must share in the cost of catastrophic coverage, but we don't think they should be expected to shoulder the full burden. We advocate a combination of financing approaches that include premiums, just as we're now paying premiums for Medicare, inclusion of State and local government employees in Medicare and a tobacco tax.

Let's talk about the medigap policy that we've been discussing today. The gap in Medicare's coverage, particularly its cost-sharing requirements, have led to the development of this type of policy. About 70 percent of Medicare enrollees are covered by such plans. The Association has urged the passing of legislation that would protect Medicare enrollees against high-cost illness by filling in the gaps in Medicare's coverage. We believe that filling such gaps through the Medicare program is the most efficient way to insure against catastrophic costs. Accordingly, we welcome any meaningful improvements in the Medicare program that will reduce the need for supplemental plans or make them unnecessary. You might say that AARP is putting themselves out of the medigap business and we'd love to do that. The only reason we provide it is because our membership can't find proper coverage in the marketplace. Nevertheless, gaps in coverage are going to remain and beneficiaries are going to continue to purchase medigap policies.

We think it's appropriate that the provisions of the Baucus Amendment, which established minimum benefits, marketing standards and performance rules for medigap policies, should be revisited and even strengthened. Specifically, we recommend that a performance standard be established at 70 percent of actual loss ratio for individual or mass-marketed policies. Because we operate on a non-profit basis, our loss ratios for our policies are 82 percent.

We also recommend several marketing standard improvements including the prohibition on lists developed through cold-lead generation, clearer disclosure notices on replacement and duplication of coverage, and a 30-day free look for all Medicare policies. If catastrophic legislation is enacted, we recommend that the minimum benefit standard be revised to correspond with the types of gaps which remain.

Efforts to improve Medicare's coverage for both acute and chronic illnesses will be undermined—as you said, Senator—unless there are adequate numbers of appropriately trained health care personnel. Health care needs of older adults differ from those of younger people, requiring specialized training in geriatric medicine. Yet the number of older persons who will need specialized care by the year 2000 will far outstrip the number of physicians trained in providing that care. Your chart shows this very clearly.

Not only are geriatric training and research opportunities limited, few medical students have been attracted to the field. Our country is confronting a serious undersupply of physicians and other medical personnel trained in dealing with special health care needs of older persons. Our association believes we should take steps now to promote the establishment of high-quality geriatric training programs at all medical schools and also to promote such training opportunities for nurse practitioners, physician assistants and other health care personnel.

Senator, we look forward to working with you and other members of the Congress seeking to bring about these improvements of special interest to older Americans.

Senator SASSER. Thank you very much, Mr. Maxwell. I've got a great number of questions I'd like to ask you. However, John Wagster, who's done such a superb job of putting these hearings together tells me I'm running way behind time. So what we'd like to do is perhaps submit some questions to you for the record, if we may.

We'll move now to Ms. O'Neal. We'd be delighted to hear what you have to say.

TESTIMONY OF LINDA O'NEAL, LEGAL SERVICES OF MIDDLE TENNESSEE

Ms. O'NEAL. Thank you, Senator Sasser. I appreciate the opportunity to provide testimony today about the health care needs of the elderly, particularly the low-income elderly. I have some written testimony which I will submit,[2] and in the interest of your time schedule, I will briefly highlight some of the issues in it.

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[2] See p. 160.

I would particularly like to focus on some of the areas that we think are most important for Medicare expansion. One of these is prescription drug coverage. Currently, it is not uncommon for the elderly to have 10–12 prescriptions that might cost $100–$200 a month. This kind of cost is obviously very difficult on limited incomes and it's very difficult even with higher resources. It is essential that Medicare begin to provide at least some assistance in the cost of prescription drugs. Failure to provide such coverage is often penny wise and pound foolish. It may result in the elderly failing to get needed medication and the consequence may be more serious illness and more costly hospitalization for nursing home care.

A second important area in expansion of Medicare are the reductions in deductibles and co-payments, the expansions in the Part B coverage or through some kind of new Part C coverage, as you have proposed. I think it's very important there be preventative provisions in these expansions. It's very important for this because if care is delayed, then it's more costly. There has to be increased assistance in the area of the deductibles and the co-payments. The particular problem is with the doctor bills. While people are most frightened by hospital bills because they are so large, the biggest danger for the majority of people are the high doctor bills and the limited payments available through Medicare. As Mr. Maxwell mentioned, the unassigned costs that are far above what Medicare pays and also are far above what medigap policies pay.

Another thing that's particularly important is the coverage for long-term care, as you have recommended. The lifetime risk for placement in a nursing home is 20 percent and only 4 percent of the elderly are in a nursing home at any one time. More than half of all nursing home patients are there for less than 3 months and 40 percent for less than 1 month. Even though these statistics indicate that it's not necessarily likely that an elderly person will be in a nursing home, this is still one of the greatest fears of the elderly, that they will wind up in a nursing home and that they will have inadequate resources to pay for such care.

There must be adequate mechanisms to pay for long-term nursing home care, and I believe that Medicare is the best means for doing this. Provisions for long-term care through Medicaid would reduce the problem of people looking for medigap insurance or for the long-term care insurance that's available and being subjected to the same types of pressures and unscrupulous dealing that have already been discussed today. It would also provide a better economy of scale in paying for this kind of care and would be available through individual policies.

The fourth issue that's closely related to this is the issue of spousal impoverishment. Provision for adequate payment for long-term care is the best means of dealing with spousal impoverishment. The result of placement in a nursing home in the community for a surviving spouse being left totally impoverished is because of high nursing home costs. The best means of dealing with this is to cover nursing home costs through Medicare. If that's not done, then the provisions that are included currently in the House bill that would at least raise the minimum income and resource requirements for spouses certainly need to be passed so that these people can live with dignity in the community while their spouses are in nursing homes.

The fifth issue that I want to mention is the financing mechanism. It's critical that there be adequate financing for this. I would disagree with the presentation by Mr. Maxwell and suggest that it is essential that those who are able to pay help pay that premium, that the premium increases to provide extended coverage have to be spread in such a way that those who are able to pay do pay it. At the present time there are people who are virtually unable to pay even the limited Part B premium that currently exists and any increases are very difficult if not impossible for them.

There are a couple things that we would suggest regarding this. One is that we would strongly recommend that there be a requirement that the states through their Medicaid programs do the Medicare buy-in, that they pay the Part B premium and any additional premiums for expansions of Medicare and that they also pay deductibles and co-payments for low income persons, the people who are below the federal poverty line. By doing this in conjunction with expansions of Medicare, it should minimize the adverse impact on the state budgets, that expansion of the Medicaid population, because the Medicare would be covering many of those costs.

Even with increases in premiums for elderly with the ability to pay, the premiums that they're still paying are likely to be less than medical insurance premiums that currently exist for younger Americans that are purchased either individually or through their employers. Additionally, because of the expanded coverage they would have less out-of-pocket costs and there should be reduced costs in the premiums for other medigap policies. So we think it's very important that the financing mechanisms deal with the elderly and it provide relief for those who are very low income. Those are the things we think are most important in expansions of Medicare.

In the area of Medigap policies, I can't add a whole lot to the very vivid descriptions that have been presented. Clearly, there are problems with unscrupulous agents, with scare tactics, with provisions that are very complex and confusing, and with the fact that many of them provide inadequate coverage. They don't deal with prescription drug care or prescription drugs. They don't adequately cover doctor bills. The elderly have unrealistic expectations that they will cover long-term care, which they do not. There are other problems with cancellations or with non-renewals of policies that can leave the elderly without coverage. I think education is one means of dealing with the problems of medigap insurance, but I think the best means of dealing with this is through expansion of Medicare so that the health needs of the elderly are better met.

In conclusion, I would really like to commend you for all the leadership and commitment that you have demonstrated in this area and urge you to continue to support the expansions in the Medicare program. Thank you.

Senator **Sasser**. Thank you very much, Ms. O'Neal. Let me ask you just two questions and then, as I did with Mr. Maxwell, I think we will probably have additional questions that we would like to for the record.

Recent news stories in Nashville talk about the growing problems of spousal impoverishment that you alluded to in your testimony. As you know, that's a situation where one partner in a marriage, because of illness, has to wipe out the couple's savings in order to become eligible for Medicaid benefits. After this is done, the other partner is often left with only the barest minimum income for essential expenses, if that much. Are you aware of specific cases of spousal impoverishment occurring as a result of soaring medical costs for the elderly?

Ms. O'NEAL. Yes. Legal Services does provide assistance to the elderly very frequently in dealing with people who have high medical bills that they cannot pay or in assisting the elderly in attaining public benefits. We do encounter these kind of cases. Part of the reason this happens is that in Tennessee, for example, if the husband is placed in a nursing home and he has been the sole breadwinner in that family, then by the time Medicaid and the nursing home takes part of his social security payment to pay for those services, if his homemaker spouse has no pension benefits or social security of her own, she's going to be left with $150 a month to live in the community. Obviously, this doesn't provide enough money to meet essentials much less pay for her needed medical care or increases in Medicare premiums and things of that nature.

Senator SASSER. What are the best Medicare policies that could be adopted to prevent the problem with spousal impoverishment, in your judgment?

Ms. O'NEAL. I think the ultimate goal is for Medicare to include complete coverage for long-term care so that we won't have spousal impoverishment. If that's not an immediately attainable goal, then the interim goal are the provisions that are included in the House legislation that would raise the income and resource limits for the spouse in the community.

Senator SASSER. That's easy to say but difficult and extraordinarily expensive to do. Both House and Senate catastrophic illness bills do not provide Medicare coverage for nursing home care, other than the skilled nursing home care that may be required after a hospital stay. Based on your work with older citizens through Legal Services, is this a deficiency that is serious, in your judgment, with regard to the problem of catastrophic health care costs?

Ms. O'NEAL. It clearly is a serious problem. It results in the spousal impoverishment. It results in people not obtaining proper care. It's one of the most serious deficiencies.

Senator SASSER. In your prepared testimony, you indicated that there's about a 20 percent lifetime risk that the average American is going to have to spend some time in a nursing home. Of course, we know that some elderly very quickly consume their lifetime savings by paying for long-term care in a nursing home. The average cost, I think, of a year in a nursing home nationwide is $22,000 a year. I suppose this fear that the elderly have of losing their savings because of a catastrophic illness is the thing that compels them to buy medigap insurance policies. That's been my feeling about it. Is that corroborated by your observations of the elderly that you deal with?

Ms. O'NEAL. It is one of the reasons that the elderly seek medigap policies. But, as you know, most medigap policies do not even address long-term nursing care. Part of it is the confusion over the difference of skilled nursing care and intermediate care. While some of them may cover skilled care, virtually none of the medigap policies cover intermediate care. The majority of people in nursing homes are in intermediate care, and there's not any coverage for that.

Senator SASSER. One final question. In your dealing with many of our elderly citizens, do you find that a majority of them are under the impression that Medicare does indeed cover their long-term health care needs?

Ms. O'NEAL. I think the majority of Americans and the majority of the elderly probably do have that feeling. Their concern about the lack of Medicare is what they obtain from television from medigap policy advertisements that focus on hospitalization, and they don't realize that the real gaps are in the areas of long-term care and payment for doctor bills and prescription drugs.

Senator SASSER. I have often thought that perhaps the Department of Health and Human Services itself ought to engage in some advertising to lay out precisely to the elderly what Medicare covers and what it does not cover, although we'd have to be very careful about that because it might cause a stampede to the medigap carriers which might be something that we'd want to avoid.

Mr. Maxwell, do you wish to make a comment?

Mr. MAXWELL. Senator, on September 21, we who have been working on a committee for Secretary Bowen will be presenting a series of recommendations on long-term care. It addresses exactly the problem that she's talking about. I really think that the Department has hesitated to publicize the fact that people don't have long-term care because they're concerned that there would be some kind of a revolution. For people who have for so long thought that Medicare covered long-term, to suddenly to discover that there's no coverage, absolutely none—they are really going to be upset about that. One of the recommendations of this task force is that there be a general distribution of an explanation to all Medicare beneficiaries explaining that it is not covered and that they should make other provisions.

Senator SASSER. You don't mean to imply there might be some serious political repercussions.

Mr. MAXWELL. Certainly not. The problem is that it's a matter of 20 years standing now.

Senator SASSER. I think we'd all be pardoned, then. One final question for you, Mr. Maxwell. As I recall, there was a poll that may have been taken by the AARP that indicated that some 80 percent—or what were the figures?

Mr. MAXWELL. Eighty-two percent of the people that we asked about their coverage for long-term care thought that it was covered by Medicare. In our written testimony, it is reported that we have recently run a couple more surveys and it's gone to about 40 percent. So we are progressing in explaining to people what this problem is. But there is no question in our minds that the big catastrophe is long-term care, not acute care in the hospital.

Senator SASSER. Well, I couldn't agree with you more.

My thanks to all of you for appearing here today and giving us the benefits of your views. My particular thanks to Commissioner Reid. I know he has a busy schedule. I appreciate him changing that to be with us here today. Thank you.

Now, I'd like to introduce our last panel of witnesses. We are fortunate today to have two distinguished physicians with extensive training in geriatrics, both from very prominent Nashville institutions. First, we'll have Dr. Richard Margolin. He's the Director of Geriatric Research in the Department of Psychiatry at Vanderbilt University Medical Center. Dr. Margolin received his medical degree at the University of California at Irvine and completed his residency in psychiatry at Vanderbilt University. If you would come forward, Dr. Margolin. He has also served with distinction as a fellow in gerontology at the National Institute of Aging.

Dr. Margolin will be joined by Dr. Rupert Francis of Meharry Medical College. Dr. Francis, if you would come forward. Dr. Francis holds medical degrees from the University of Manitoba and the University of Jamaica. He completed his residency in family medicine at Meharry Medical College and is currently studying a wide variety of issues related to geriatric care.

Dr. Margolin, if you would be first.

TESTIMONY OF RICHARD MARGOLIN, M.D., DIRECTOR OF GERIATRIC PSYCHIATRY, VANDERBILT UNIVERSITY MEDICAL CENTER

Dr. **Margolin**. Senator Sasser, thank you very much for the opportunity to participate in this important hearing. This hearing is important not only to Americans who are now 65 and older, it is also important to baby-boomers like myself because unless we as a nation commit the resources to improving the manner in which health care and other services are financed and delivered to those currently over 65, the system will collapse under the weight of my generation in the decades to come.

As Director of the Division of Geriatric Psychiatry at Vanderbilt and Staff Psychiatrist at the Nashville Veterans Administration Medical Center, I see first-hand the complex nature of the health care problems encountered by the elderly. In the interests of time I won't repeat all the statistics which you have so ably introduced earlier on this morning. Suffice it to say that, unlike younger Americans, those over 65 suffer from multiple and often coexisting acute and chronic diseases. They have many causes of functional disability including sensory impairments such as vision and hearing loss, motor impairments such as from arthritis and stroke, and mental and emotional impairments such as due to depression and dementia. Of great importance is the fact that the elderly are less resilient than the young to the debilitating effects of the combination of these illness and losses.

Because of the unique health care problems that result from aging, specialized training is extremely important in the care of the elderly. Research has shown that aging alters both the physiologic and emotional responses to disease and our therapeutic interventions. Detailed knowledge of these differences is crucial to successful care of the elderly, but is often lacking among physicians, psychiatrists and other health care workers because it has not been taught. High quality geriatric care involves skills and attitudes different from those required for care of adults in the middle years of life. Tolerance of the inevitability of declining function and the inability of even our powerful modern methods of treatment to alter the course of some diseases calls for special sensitivity and patience among physicians and other caregivers.

As a geriatric psychiatrist with some training also in internal medicine--I guess I'm one of the rare breed that you talked about—I often see patients whose poor health status can in part be attributed to the problems we are discussing today. I would like to cite just one specific example to you.

Because of agitation, an elderly woman residing in a nursing home was placed on a certain medication. Perhaps due to lack of knowledge about the special sensitivity of the elderly to this drug, an excessively high dose was used. Consequently, this patient experienced a known side-effect of the medication which was then misinterpreted as a seizure. As a result of the misdiagnosis, she was placed on anti-seizure medication while still continuing on the excessive dose of the first medication. She remained over-medicated and wrongly medicated for a number of weeks, suffering needless morbidity. Knowledge of geriatric physiology would have prevented this entire sequence.

Senator Sasser, I think you can see from this example why those of us with a special interest in the care of the elderly welcome so enthusiastically your efforts to expand the number of geriatricians in this country. Senate Bill 1112, "The Centers of Excellence in Geriatric Research and Training Act of 1987," will begin to put in place the creative framework required to increase the number of appropriately trained physician-teachers, practicing physicians and other health care professionals so urgently needed to care for our rapidly expanding elderly population. As you well know, the current number of trained geriatricians is woefully inadequate. Of the 450,000 practicing physicians in the United States, as you have indicated, only 450 have completed post-graduate fellowship training in geriatrics, 1 in 1,000. The situation is even worse in psychiatry with only 400 psychiatrists even identifying themselves as specialists in the mental disorders of the aged and less than 50 to 100 having had any formal training in this area.

In a study recently released by the Institute of Medicine, it was estimated that we need to double the number of practitioners with training in geriatric medicine by the year 2000, and that is just the first step. By increasing the number of geriatricians two-fold, we will have only trained the trainers. As you have indicated, although 75 percent of medical schools now offer elective courses in geriatrics, only 4 percent of American medical students choose to take them. Academic leaders are needed, first of all, to attract others to the field of geriatrics. It is a very rewarding field. The skills and training of geriactrician-teachers are needed to demonstrate that fact to medical students in training because they are the ones at the formative stage of their careers.

Unfortunately, the need for trained geriatricians is emerging as a crucial national priority just as the financial constraints on our health care system have also reached crisis proportions. Yet a way must be found within these constraints for the health care needs of the elderly to be properly met. Frankly, geriatrics is time-consuming and difficult work. The DRG and Medicare physician payment systems penalize geriatricians and geropsychiatrists and render their task even more difficult than it need be. This is so because these payment systems favor procedure-oriented care over cognitive care and because they are based on "average" costs. It is a fact that the elderly patient is almost never average.

Let me speak directly to the mental health needs of the elderly because this is my personal area of expertise. Medicare's program in this area is frankly a travesty as well as not being cost effective. Mental disorders such as depression and dementia are very common and quite serious among the elderly. The suicide rate, for example, is highest of all among elderly men. Yet Medicare's coverage of outpatient mental health care is trifling. The same annual limit of $250 per year for outpatient mental health services has been in place since the inception of the program in 1965. What is to me absurd about this is that by not enabling adequate outpatient care, problems are allowed to fester until much more expensive inpatient care is often necessitated.

I believe that improved geriatric care systems which are also cost effective can be developed if we stress training and prevention, and if we tailor benefits to the true needs of the elderly. This could be accomplished, for example, by expanding home health care and day care services because these services prevent expensive institutionalization. The long-term care issue must also be addressed and, frankly, soon. In my work primarily with Alzheimer's Disease, there is no greater problem among families with a loved one so diagnosed than the fear of poverty as a result of paying for long-term care. In this regard, Senator, your bill proposing a Medicare Part C is a laudable and important step.

Very briefly, stepping back from these important details, though, let me reiterate my view that the cornerstone for an improved system of care is education. That is why the passage of the Centers of Excellence Bill is so important. It represents a very efficient use of limited resources. Health care dollars need to be spent on care that truly improves the quality of life for older Americans. The establishment of geriatric centers of excellent with appropriate funding levels would permit the training of capable individuals so urgently needed to serve as leaders, whether in medical schools or in communities throughout America. These individuals would have an impact on medicine and society far in excess of their actual numbers. Biomedical and psychosocial research is yielding an explosion of information about the aging process. That information will not be translated into improved patient care, however, without support for the training of specialists.

If we are to achieve the recommendations of the Institute of Medicine, congressional leadership and action is needed. We count on you to be a strong advocate of these needs. I'd like to simply add that although it's very flattering to suggest that one such center might be located at Nashville and even at Vanderbilt, I would like to emphasize the cooperative nature of our incipient effort in geriatrics in Tennessee. I have helped to arrange for a gathering of academic geriatricians from all four of our medical schools here in

Tennessee, and we look forward to a cooperative relationship in which the strengths of each school can contribute to a state-wide effort. Tennessee is too small a state and we are too far apart from each other to have competition. What we need is to emphasize the strengths that we have and work together. Thank you, Senator.

Senator **Sasser**. Thank you very much for your very enlightening testimony.

Perhaps I should have also included the possibility of putting a center of geriatrics at Meharry. I think that might be an excellent idea. We'll turn to you now, Dr. Francis.

Dr. **Francis**. Thank you, Senator Sasser. Of course, I like that last idea you just mentioned.

Senator **Sasser**. I thought you would like that.

TESTIMONY OF RUPERT FRANCIS, M.D., CHAIRMAN, DEPARTMENT OF FAMILY AND PREVENTATIVE MEDICINE, MEHARRY MEDICAL COLLEGE

Dr. **Francis**. I appreciate the opportunity to discuss with you the proposed legislation on catastrophic health care and geriatric centers of excellence. These pieces of legislation are excellent foundations for approaching the problems of long-term care for the elderly and the need for more physicians specializing in the field of geriatric medicine.

The current Medicare program has become essential for a large segment of our elderly population but it does not nearly fulfill all of their health care needs. The most attractive part of the proposed catastrophic health care insurance legislation is the redefinition of long-term care to include other non-institutional and community based services. As the size of the elderly population and the number of people with functional daily living impairments in the community increases, the demand and cost for not only nursing home services but also home care and other non-institutional services can be expected to grow. Long-term care as broadly defined by the proposed legislation will respond to the needs of a much larger group of people and ultimately aid in the coordination process. In other words, if the options for home care, day care and community-based services are readily available and funded, the probability of the patient being referred to the most appropriate and cost effective environment will be increased. The current prospective payment system provides hospitals with the incentive to discharge patients early and/or prematurely. At the same time, the long-term care industry is not adequately prepared to receive ill patients. Elderly patients have been viewed by the hospitals as burdens and a source of increased costs rather than as opportunities for service. Therefore, without the redefinition and inclusion of long-term care in the catastrophic health insurance bill, this catastrophic health insurance bill will not be as useful or marketable.

The legislation proposing the geriatric centers of excellence recognizes that the biological and physiological changes associated with aging dictate the need to train health care professionals who are aware of these changes and who will be better prepared to treat the elderly. Without trained geriatricians, even the best of legislation may not provide health care that is adequate for the elderly. As Dr. Margolin stated, estimates are that 450 of the 450,000 practicing physicians in the country today have completed a postgraduate fellowship program in geriatrics. Increasing the availability of training programs that provide adequate salaries for trainees will become initial incentives to attract more physicians to seek additional training in caring for the elderly. More schools now include geriatrics in their curriculum. The number of geriatric fellowship programs have increased. Also, there is an increasing emphasis on the geriatric content in residency programs. However, it still remains doubtful that even if enough geriatric-oriented physicians who are trained and motivated to participate in the care of the elderly, they would not be prepared to address completely the full range of problems faced by the aged. If the health care system is to adjust appropriately to the growing needs for health care services for the elderly while at the same time trying to maintain or contain health care costs, emphasis must also be placed on the use of other non-physician manpower.

I would like to focus briefly on two findings of need not addressed in the proposed legislation. First, there are disparities in the health status of blacks and minorities as defined in the Report of the Secretary's Task Force on Black and Minority Health. This comprehensive report outlines the critical differences in health status between blacks, other minorities and whites. The fact that blacks and other minority elderly have higher rates of chronic disease, functional impairment and indicators of risk such as hypertension than whites lend credence to this need. The sobering statistic is that each year 60,000 more blacks die in this country than would die if blacks had the same age-adjusted death rates as whites. Although similar health services are received, there are differences in patterns of utilizations between the groups. Much is still being attributed to poorer access to and the use of comprehensive and high-quality health care.

Secondly, there is continuing under-representation of blacks and other minorities in the health professions in general and particularly in geriatrics. The degree to which well trained health care are available plays a crucial role in reducing many of the disparities in health status between minorities and other minorities and therefore must be given some consideration.

Research and training in geriatrics is not new at Meharry. Beginning in 1978, a group of concerned Meharry faculty initiated the concept of a comprehensive geriatric/gerontology program. In 1982, the Gerontology Center was inaugurated and the staff was hired in June 1983. Its primary focus has been education and training of the health care providers in the areas of aging. Other existing programs include an acute geriatric unit, a state-certified 20-bed skilled nursing unit, a Robert Wood Johnson Foundation funded hospital initiative in long-term care CARES Project, a dental geriatric unit, three funded geriatric development awards, a geriatric fellowship program in family medicine, a Geriatrics Day hospital program and a regional Geriatric Education Center. I am also pleased to say that Meharry Medical College has been successful in attracting one of the few blacks trained in geriatrics who will begin her tenure at Meharry in February of next year. These are some of the examples of the extensive efforts in geriatrics/gerontology at Meharry at the moment.

Because of Meharry's uniqueness and its past efforts in the area of geriatrics/gerontology and its recent designation as a Center of Excellence in Minority Health Education and Care, it should be considered for designation as one of the ten Geriatric Centers of Excellence. A funded center here at Meharry would improve the plight of the elderly, particularly the black and poor, and directly respond to its mission, a mission to provide access to care for the poor and underserved and access to health professional education for blacks and other minorities.

Thank you, sir.

Senator **Sasser**. Thank you very much. Let me say to you, doctors, that we've run out of time here. There are a number of questions I'd like to ask. There is one question that I must ask. I want to ask you, Dr. Margolin, why you think there's such a shortage of people in your field. I want to ask both of you if you think my legislation will help with the problem.

Dr. **Margolin**. Very briefly, Senator, in psychiatry there has long been, I think, a bias against the view of the mental disorders of the elderly as being treatable and significant. Our research in the past several decades has really debunked that myth. We in psychiatry do have a long way to go in catching up with even the limited abilities and resources in internal medicine. Very briefly, to comment on why your bill will help this, it is precisely in the area of stimulating interest at the levels of medical students and residents in training that we're able to impact and change the future.

Senator **Sasser**. Thank you. Dr. Francis, what do you think? Is my legislation going to be helpful in trying remedy the shortage of people in the field of geriatrics?

Dr. **Francis**. Very much so, sir.

Senator **Sasser**. That's what I hoped you'd say.

Dr. **Francis**. One of the most important spinoffs from this is the sensitization of the community and the medical professionals to the need. That is going to result from all of these hearings. Your legislation I think will go a far way, at least the Centers of Excellence portion of the legislation, in helping us to recruit more people to undergo training at the post-graduate level, the post-residency level in geriatrics. What we find when we try to recruit people is that so many of our medical graduates who have gone through their residency owe so much money that they have to start paying by that time. They can't really afford to still pursue another low-paying training period for another two to three years. So they have to go into practice. However, there are real factors that in family medicine when you go out to practice you are faced with at least half your patients being geriatric patients anyway, so you find you do need the training. If we have the resources to attract these people back into training—and when I say "resources" I mean centers for training and the finances to afford these salaries—I think we will find a lot more people going into the geriatric field. Thank you, sir.

Senator **Sasser**. I want to thank both of our distinguished physicians for appearing here this morning and giving us the benefit of their views, and they're very helpful. I want to express my appreciation to all of our witnesses for appearing here today and giving us their assessments, particular those witnesses who traveled some distance. I also want to thank our very excellent staff here for their hard work in preparing for these hearings, and I now declare these hearings adjourned.

[Whereupon, at 12:10 p.m., the Subcommittee was adjourned to reconvene at the call of the Chair.]

RESOLVING CATASTROPHIC HEALTH PROBLEMS IN THE MEDICARE PROGRAM

FRIDAY, AUGUST 28, 1987

U.S. SENATE,
SUBCOMMITTEE ON GOVERNMENT EFFICIENCY,
FEDERALISM AND THE DISTRICT OF COLUMBIA,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Memphis, TN.

The Subcommittee met, pursuant to notice, at 10 a.m., at the Oakville Health Center, 3391 Old Getwell Road, Memphis, TN, Hon. James R. Sasser, Chairman of the Subcommittee, presiding.

Present: Senator Sasser.

Staff Present: Dr. John Callahan, Staff Director, John Wagster, Legislative Assistant, and Calvin Anderson, Special Assistant.

OPENING STATEMENT OF SENATOR SASSER

Senator SASSER. The hearing this morning of the Subcommittee on Government Efficiency and Federalism of the Government Affairs Committee of the U.S. Senate will come to order, and I thank our reporter for being here this morning and taking down these proceedings. And I want to thank all of you who come here today to testify, especially those who might have traveled great distances to be here.

Yesterday in Nashville we heard some excellent testimony regarding the problems that many of our elderly citizens are facing. Today's hearing will focus on the tremendous burden that our older citizens face in trying to pay for catastrophic health care. We will discuss ways that might ease that burden. We will also discuss the quality of health care that many of our senior citizens are receiving.

As the population here in the United States grows older, and make no mistake about it, it is growing older every day, Social Security and Medicare are having a greater and greater impact on the Federal budget.

Now Social Security and Medicare taken together account for more than $300 billion in Federal spending and that's about one-third of our Federal budget. Now to counterbalance that, the Federal Government collects Social Security taxes, collects funds to help defray the costs of Medicare, so actually it is self-sustaining at the present time. But while these expenditures are great, they have only helped to make old age livable. They have not solved what one noted geriatrician and Pulitzer-prize winner, Dr. Robert

Butler, describes, and I quote him, "the tragedy of old age in America."

The tragedy, of course, is that most of our elderly live in constant fear of financial ruin from a catastrophic illness, and I think their fears are well-founded. Tragically, the threat of financial ruin from catastrophic illness will grow worse as our population here in the United States continues to age.

Over the past two decades the number of Americans who are 65 years of age or older has grown twice as fast as the rest of our population, and the growth of this elderly population in proportion to the rest of our population will continue well into the next century.

As you can see from this chart here,[1] this is the growth of our population now at 65 years or older. In 1900, 4 percent of our population was 65 and older. By 1980, 12 percent of the population of the United States was 65 or older. By the year 2000, 13 percent, and that's just 12 years from now, thirteen percent will be 65 and older and by the year 2050, almost one in every four people in the United States is going to be 65 years of age or older. And even more startling, there will be nearly an 800 percent increase in the population of the very elderly, and that is 85 years of age or older by the year 2050. In 1980 we had 2.2 million people who were 85 years of age or older. By the year 2050 we will have over 16 million people in the United States who will be 85 years of age or older.

Now I think we should certainly thank the good Lord and medical science that so many of us now live to an advanced age, but this graying of America promises to greatly magnify the problems in our present health care system, and our health care system, make no mistake about it, is already strained by the heavy demands of a population that is growing increasingly older.

The elderly are by far the heaviest users of health care services in this country. According to the National Center for Health Statistics, persons age 65 and older are in the hospital twice as often as younger people, and when these people 65 years of age and older go into the hospital, they stay twice as long as those who are younger and they use twice as many prescription drugs when they are 65 years of age and older than those who are younger.

So it should come as no surprise that as one grows older, the likelihood of being stricken by catastrophic illness which requires long-term care increases very dramatically. The increase is most dramatic among the fastest growing segment of our elderly population, and that is those who are 85 years of age and older.

In 1984 the National Center for Health Statistics reported that one in every three Americans over age 85 required some form of long-term intensive care yet the elderly currently have almost no options available to them to help pay for expensive, long-term care. Most now quickly exhaust their own limited assets, paying for nursing home care and it's no wonder, because the average cost of nursing home care in the United States now runs to $22,000 a year. The Department of Health and Human Services reports that as many as one-half million elderly persons a year, that's 500,000 people, have to exhaust all their assets, spend down to the Medicaid limit, if that means selling their house, getting rid of any asset that they have so that they can access Medicaid and get into nursing homes and get Medicaid help.

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[1] See p. 3.

This statistic shows that it is starkly evident that existing problems are large and that existing programs are falling far short of addressing the problems that need to be addressed. For every dollar that Medicare spends, 94 cents of that dollar goes to pay for hospital costs or for doctors' bills. Only 1 cent of every Medicare dollar goes to help pay the costs of nursing home care, and that is a great tragedy.

Polls indicate that as many as 80 percent of our older citizens do believe that should they become ill that Medicare will take care of their long-term expenses including nursing home care and that simply is not true. A relatively large share of the elderly's out-of-pocket health care expenses, that which they pay themselves and they pay about 42 percent of their own health care expenses out of their pockets, goes to cover the costs of nursing home care.

The painful truth is that there are currently great gaps in the Medicare coverage, gaps which our older citizens now have to fill with money from their own limited assets, and despite the Herculean efforts that the Federal Government has made over the past 20 years, the direct, out-of-pocket health costs for the elderly averaged about 15 percent of their income in 1984 and that's precisely the same percent of their income that they were devoting to health care expenses prior to the enactment of Medicare and prior to the enactment of Medicaid.

So partly out of frustration and partly out of fear, our elderly citizens are purchasing supplemental health insurance commonly referred to as "medigap policies," and many of them believe that their supplemental medigap policies will pick up everything that Medicare doesn't pay for, yet these medigap policies do not do that. Most of these policies cover none of the costs of nursing home care, and they do not then fill the largest gap left by Medicare.

Often our elderly citizens find themselves victims of unscrupulous medigap salesmen who play on the fear of the elderly of catastrophic illness and convince them to buy one or sometimes several unneeded policies. I have heard of cases where individuals are paying literally over $1,000 a month for multiple medigap policies that duplicate coverage that they already have and which do not offer the essential coverage that the elderly person really needs.

Both the Administration and the Congress are now coming to grips with the fact that private insurance alone cannot handle the health care needs of our elderly population. We're seeing action to offer protection to our senior citizens in order to protect them from the financial ravages of their health care needs. Earlier this year Dr. Otis Bowen, the Secretary of the Department of Health and Human Services, issued a report on catastrophic illness expenses, and this report served as a blueprint for legislation which passed the House of Representatives earlier this summer, and when the Senate returns to session shortly, we will quickly take up a bill very similar to the House-passed measure. Therefore, I am looking forward this morning to the comments of some of our witnesses on the bill which is now pending in the Senate.

While I am pleased that we are seeing some movement on this whole issue, I must say that I am disappointed that neither the bill passed by the House of Representatives nor the bill that's being considered by the Senate adequately addresses the elderly's most common catastrophic health care expense, and that is the need for long-term care. This is a critical shortcoming which calls into question the effectiveness of the proposals that are now being advanced by the Administration and the proposals that are now clearing both Houses of Congress.

I introduced legislation this year in the Senate and Congressman Claude Pepper of Florida introduced similar legislation in the House that would address the problem of long-term care and many other types of catastrophic costs. The legislation that we introduced would cover long-term and extended hospital stays as well as the major health care expenses of the elderly including routine doctor visits, dental expenses, the cost of eye problems, hearing aids, and things of that sort. And while we made a good start, I think, by introducing and passing the House bill this year, we have still a long way to go and we need, in the final analysis, to adopt legislation that is similar to that that I've introduced in the Senate and that Congressman Pepper has introduced in the House of Representatives.

Let me focus on one other matter before we begin taking testimony from our witnesses. The elderly have a special need for medical attention. We need to focus on the study of geriatrics and that is the medicine that addresses the special needs of older people. We must recognize that most of our older citizens often suffer from a whole host of chronic and sometimes multi-dimensional illnesses that are very difficult to treat. We must recognize that there is a need for specialists to tackle the specialized illnesses of older people.

Now we have pediatricians who specialize in illnesses and problems of children, but we need to have geriatricians to take care of the particular needs of older people. There is a severe lack of geriatric training presently in the United States. For example, although 75 percent of American medical schools now offer election courses in geriatrics, only 4 percent of the medical students choose to take these courses, and for advanced geriatric training, the figures are even worse. In the current academic year there are only three geriatricians that are being trained across the United States and only one geriopsychiatrist to deal with the mental problems of older people is in advanced training in the entire United States of America.

Why do we have this scarcity of geriatricians? For one reason, treating older people is not very glamorous for our medical students. One of the most satisfying rewards of being a doctor is being able to make people better and to see that your work is helping people. When a physician treats an elderly person, many times there is no "quick fix," and many times the improvement, if any, is very, very slow and very, very gradual and so for this reason it's not appealing. It's not as gratifying to physicians to treat older people and to specialize in geriatrics as it would be in treating younger people or children.

What do we do about this problem? I have advanced legislation that would establish national centers of excellence in our medical schools of this country for geriatric training, and these centers would train specialists who were dedicated to improving the quality of health that our senior citizens are receiving. We are going to address this issue when we debate the catastrophic health bill in the United States Senate. It is clear, I think, to all of us that much work needs to be done and whether we are talking about catastrophic health care insurance costs or the lack of geriatric training across the country, these are issues that deserve prompt and thorough attention.

I'll just finish by saying this. We have to put behind us the days when elderly Americans must impoverish themselves, must sell their homes, must sell their possessions, must contemplate a legal divorce from their spouse so that they can access the Medicaid system and pay for adequate health care. We need to make that just as obsolete as we made the poorhouse in the 1930's. We should move beyond a health care system that fails to recognize the special needs of an elderly population, particularly at a time when our population is growing older and older every day, and I think the contributions of these witnesses here today will be very helpful to us.

We are going to have three panels of witnesses, and our first witness or rather our first panel will consist of Ms. Faye Parnell of Trenton, Tennessee. Ms. Parnell teaches the first grade at the Peabody Elementary School in Trenton. Her father started showing signs of Alzheimer's Disease 5 years ago and has been in a nursing home for at least 3 years. Will you come forward, please, Ms. Parnell.

She will be joined by Ms. Iris Welborn from Collierville, Tennessee, and if you will, come forward, Ms. Welborn.

She and her husband are both retired from a family business. Ms. Welborn's husband started showing signs of Alzheimer's Disease several years ago. She cared for him on her own until the physical and emotional strain simply was too much for any individual to bear, and then he was confined to a nursing home.

They will be joined on the panel by Ms. Margie Nichols, an investigative reporter and producer for WSMV in Nashville, and let me say that Margie Nichols has recently completed an indepth series on the problem that many of our elderly are having with Medicare supplemental insurance policies. She testified at our hearings in Nashville yesterday, and her testimony was so enlightening that we asked her to come to Memphis so that those here in this hearing room and those who might hear her by way of television, or radio or read about her testimony in the newspaper will also know about it. I think that Ms. Nichols' marvelous job of reporting in Nashville was in the highest traditions of journalism and I want to applaud her efforts and I hope she is going to win a prize for it. She certainly ought to.

Why don't we start this morning with you, Ms. Parnell. I understand that you have three immediate family members who suffer from Alzheimer's Disease. Would you just tell us what would these family members do if you were unable to care for them yourself and do you care for them yourself?

TESTIMONY OF FAYE PARNELL, TRENTON, TN

Mrs. **Parnell**. My father, as you have stated, is in a nursing home and has been for 3 years. One sister has also been there about 5 years, and her care is being financed by her teacher retirement, Social Security and using up her savings. The other sister at this time is being cared for by a sister. However, it will not be very long before she will be facing long-term nursing care. The two sisters lived together and their home has been sold and their care has been financed using that up and when that is gone, they will have to turn to Medicaid or whatever services are available in that way, and I take care of the financial record keeping and so forth but if they didn't have anyone in the family who could do that, of course, a legal guardian or conservator would have to be appointed to do that.

Senator **Sasser**. So in essence, the two sisters are going to exhaust all of their assets for long-term health care in the nursing homes?

Mrs. **Parnell**. That would be right.

Senator **Sasser**. They will have to spend everything they have and then they will be able to access the Medicaid services?

Mrs. **Parnell**. That's right.

Senator **Sasser**. Did you tell us, Mrs. Parnell, your mother and father have Alzheimer's Disease also?

Mrs. **Parnell**. Just my father.

Senator **Sasser**. Did your mother and father have supplemental insurance to help pay for what was not covered by Medicare?

Mrs. **Parnell**. Years ago when they were preparing for retirement, they took out policies that they felt like would be adequate to meet whatever needs that might arise. Of course, at the age that they became eligible for Medicare they included Medicare, then they took out a policy that was supposed to be the supplement to Medicare that met the needs that Medicare did not.

Senator **Sasser**. Would you call this a medigap policy?

Mrs. **Parnell**. Perhaps. Of course, 15 years ago we wouldn't have put that label on it probably but it was set up to take care of the costs that Medicare did not. However, they continued to keep a policy that they had ever since I was 7 years old and then added one that would also be of help in times of—if they should have an accident. My mother pays a total of $2,100 per year for these insurances and received approximately $150. This past year she received a $150 to help her on the costs that she has been out.

Senator **Sasser**. In other words, she is paying $2,100 a year in premiums for the policies and received back only $150 to help defray the costs of the nursing home or other medical expenses?

Mrs. **Parnell**. Right. And her total, which I have that in my prepared statement, but the total amount that she has been out this past year for nursing home care and medicine and doctor bills for my father amounted to $16,000 and $150 of that was reimbursed by insurance.

Senator **Sasser**. Why don't you just give us your prepared statement. I think that might cover it better than I could by my questions.

Mrs. **Parnell.** I am very concerned, as was stated earlier, about the services and care available to the elderly who need long-term care for catastrophic illness because of the three cases of Alzheimer's Disease in my family. I believe we have covered pretty much about the two little sisters.

Senator **Sasser.** Why don't you repeat it. We want to make a record of it.

Mrs. **Parnell.** Okay. One sister is 83 years of age and has been in a nursing home about 5 years. She is a retired high school language teacher so she finances her care through teacher retirement, Social Security and by using up her savings. The other, as I said, is at this time being cared for by a sister but within a very short time will require nursing home care. My father is 81. He has had the disease about 5 years and has been in a nursing home for about the past 3. He began with what almost seemed like a sudden onset of the disease following a respiratory infection. One of the earliest symptoms was hallucinations concerning two of the most basic and secure things in his life, the identity of his wife for 55 years and whether he was really in his home or not. He thought almost from the onset of the disease that there was an imposter who dressed up to look exactly like my mother and that he was often taken to another house which also looked very identical to his own. Therefore, he was haunted every waking hour with the fear, insecurity, and restless pondering as to whether this was the real wife and home or the fake one where evil and suspicion lurked.

Unless I should mislead you, let me point out that Alzheimer's Disease is not a mental illness but it is a degenerative disease of the brain, meaning that brain cells are dying and at this point no one knows why. Needless to say, the 2 years when my mother cared for my father at home were almost unbearable for her as she wrestled with his confusions, hallucinations, inability to handle finances, forgetting grandchildren, forgetting how to dress himself or to find his way around in the house, getting lost in the community, becoming incontinent and finally becoming very hostile, all of which are very common symptoms of Alzheimer's Disease.

As my mother who was 77 at the time all this began cared for him at home, my one sister who lives 80 miles away in Memphis would run her husband's kidney dialysis three times a week, work part time to try to keep things together for her husband, and daughter, and drive back and forth between Alamo and Memphis as much as she possibly could to help. I would teach school, care for my husband, two daughters, drive 20 miles from Trenton about two or three times a week, and spend Saturdays and Sundays helping out. We also hired and lost six different people during the last year that she kept him at home in an effort to try to relieve her of part of the stress and frustration and loneliness that she was going through. It's virtually impossible to secure and keep persons to help with home care of an elderly man who is still strong and healthy physically yet not able to think clearly.

Finally, when mother had reached her breaking point and Dad had attempted to hurt her, thinking she was a stranger, we had gone as far as we could go. The day we took our loved one to the nursing home was the saddest day of our lives and the strangest. We felt and expressed our grief as though he had died and yet we hugged, kissed and expressed our love to a physically healthy body. We are very fortunate in that he is in a nursing home that does provide adequate care. It's only a few miles from my 81-year-old mother's home, so she drives the distance every day to feed him his lunch and tries to address his needs for him to the nursing home staff since he is incapable of expressing them for himself.

His attempts at speech now are only in a whisper and incoherent. He can no longer walk, has for a period of time up to a week forgotten how to eat only to begin again just before the doctor decides to have a feeding tube inserted. With the good physical condition he is in, we realize the disease may take a prolonged course with him which will mean a gradual decline over many more years, 5 to 10 years longer being very possible and ending as he wastes away in the same fetal position in which he developed for life as an infant.

My father grew up in a rural area, had very little education, and with my mother by his side every step of the way worked very hard to provide for his family. Farming was all they ever knew and from sharecropping as a young couple, they went on to purchase their own 80-acre farm and struggled to finally be able to call it their own many years later. When my sister and I were growing up they sacrificed to see that we had the things we needed in a material way and that we received the education we wanted after high school so that we might be equipped for an easier life than they had had. At this time it's costing my mother more than $16,000 per year for my dad's nursing home care, medical and doctor bills. Their total taxable income is only $13,400 per year. Of course, she is gradually using up the savings they had been able to have.

During the 3 years of nursing home care his costs have totaled approximately $50,000. Although she pays more than $2,100 annually in insurance premiums for them, she collected only a total of $150 last year.

You can have no idea the stress and anxiety my mother goes through daily over the financial burden she bears in helping pay for nursing care for my dad, knowing that over the long haul ahead, she will have to use every savings and resource of any kind, leaving her to finish her later years destitute except for whatever my sister and I may be able to provide for her.

Yet we are the lucky ones. Most people could not have made it this long without having to turn to their children for financial help. Most nursing homes, especially in cities, also charge a much higher fee. Yesterday's edition of USA Today stated that caring for an Alzheimer's patient costs about $18,000 per year, and they got their information from September's issue of American Journal of Public Health.

It's been estimated that one in three families has someone with Alzheimer's but there are so many more to add to that who have other catastrophic illnesses requiring long-term nursing care, perhaps at least two of every three families when you consider all of these together. Imagine an elderly spouse of a person as sick as I've described my father to you still after 5 years or more, being the only caretaker and keeping them in their home because they know there will be no money left for them to live on if they had the costs of nursing home care.

I am reminded of a man who related his experiences in caring for his wife and told about being so tired that many nights he would make his bed on the floor in front of the bedroom door in order that his wife would not be able to get up and leave the room without his realizing it in the night. There are simply no funds, no human resources, no service agencies to help in many of these situations and insurance, including Medicare, which most of them have always thought was going to help in such instances simply did not. My father, along with many thousands of other people facing long-term nursing care for catastrophic illnesses, need financial help.

Senator SASSER. Thank you very much, Ms. Parnell, for that very moving and very informative statement. Let me ask you this question. When your parents bought their supplemental insurance, I assume they thought that covered everything that Medicare didn't cover. Is that your understanding?

Mrs. PARNELL. Yes. I think that I can remember hearing their discussions at that time when those of their age were reaching retirement age and their discussions concerning the fact that they thought the supplemental policy and the Medicare would take care of it all, and of course, Medicare does not want to pay but for one nursing home visit per month by the doctor, and most recently my father has had a very severe chronic ear infection to act up, and it has been necessary for the doctor to see him two and three and four times a month. She receives a very small portion of the cost of one of those visits, and her drug bill runs anywhere from $100 to $150, around $150 these months when there's anything extra such as the ear infection, and none of that is covered.

Senator SASSER. If I understand your testimony, your mother pays $2,100 a year in additional insurance premiums for additional insurance over and above Medicare.

Mrs. PARNELL. No. I've included the cost of Medicare in the $2,100.

Senator SASSER. What is the figure less Medicare?

Mrs. PARNELL. Seventeen hundred, I believe. I believe Medicare is $208 for each person, if I'm not mistaken.

Senator SASSER. So she is paying about $1,700 a year for supplemental insurance over and above Medicare?

Mrs. PARNELL. That's right.

Senator SASSER. And for that $1,700 a year, she received back last year $150 in benefit payments?

Mrs. PARNELL. That's right.

Senator SASSER. Mrs. Parnell, I have introduced legislation in the Senate that would require that Medicare recipients who are financially able to do so, to pay a slightly larger premium than they now pay for Medicare but one that would be considerably below the seventeen hundred dollars that your mother now pays annually for additional insurance. Based on your experience, do you think your parents or you would be willing to pay 10 to 15 percent more for their Medicare insurance if they could get long-term health care coverage?

Mrs. PARNELL. She would be very happy to do so because that would be considerably less than what she is now out, and the total cost would be less than 1 month of long-term care costs, and I would certainly take it as soon as it was available to me.

Senator **Sasser**. What would be your reaction to the fact that the coverage under this new Medicare would be mandatory, that is, it wouldn't be voluntary? It would be a mandatory coverage just as under the Social Security system or just as under the present Medicare system?

Mrs. **Parnell**. I think that would probably be the only way to get some people to take it because they don't realize the great need that they probably will have for it if they live very many years past 65. I wonder if there are people out there who would not be able to pay that amount. I'm thinking in terms of like $50 to $100 a year, you know, I don't know what other people's income would be, but I would assume that there are a lot of people whose income is very limited. What would they do if it were mandatory?

Senator **Sasser**. They would do the same thing they do with the present Medicare system.

Mrs. **Parnell**. That's true, too.

Senator **Sasser**. But the thought is that if it is not mandatory, what you just get are the sick people signed up for it or those who would believe they run a high risk of becoming ill and then it, simply financially, it will not fly at all so you have to spread the coverage across the population and when that is done, the cost is relatively modest and everyone gets the long-term care.

Mrs. Welborn, could you tell us a little bit about your situation? I think you have indicated that your husband has Alzheimer's Disease and that you cared for him yourself initially and then you later put him in a nursing home as I understand it. Would you just tell us a little bit about your circumstances and what occurred with him initially and why you were later forced to put him in a nursing home.

TESTIMONY OF IRIS WELBORN, COLLIERVILLE, TN

Mrs. **Welborn**. My husband and I retired from a small business we owned in 1972 with income that we thought was sufficient to take us through our golden years. And we sold some property and the income that we thought we had coming in was plenty then, but as the cost of living increased we had to dip into our savings quite frequently to pay insurance and home owner's and car insurance and things like that, but we managed.

My husband was a good financial manager and we managed to get by on what was coming in, but in 1985 I had cancer surgery and in the fall of that year my husband was diagnosed as having Alzheimer's Disease. He began by losing his memory and it was hard on him not being in complete charge of himself and situations at home because he had always been head of the family, and I had to take over the responsibilities of the finances and things that he did, like he always changed the oil in the car and things that, you know, would save us money until he got to a place where he put the oil in a different place where it shouldn't be, and he began putting his clothes on backwards.

Finally, I had to shave, bathe and dress him and it just got too much for me because my health wasn't good, and after two years he just finally lost control and I had to place him into a nursing home in March and we thought we had insurance to cover that.

Senator **Sasser**. What type of insurance was it, Mrs. Welborn?

Mrs. **Welborn**. We had Medicare and Blue Cross and AARP, and we found out that they don't pay anything.

Senator **Sasser**. I want to make this point. You have Medicare. You have Blue Cross and you have insurance through the AARP. None of those policies gave you any help on nursing home care?

Mrs. **Welborn**. Medicare paid $72.22, I have paid $10,308.42.

Senator **Sasser**. I didn't mean to interrupt. I just wanted to emphasize that point.

Mrs. **Welborn**. The nursing home bill right now is costing me more than the income that we have coming in, which leaves me to draw out of our savings for my living expenses and also pay additional to the nursing home because insurance does not pay for some of his medicine, and his bills have been more than our income that is coming in, and the property that we sold will be paid out in approximately 2 years and by then, our savings will be gone. And I think that we desperately need something to help people who are faced in this situation because his is long term as are most people who enter a nursing home. They are long term.

Senator **Sasser**. So you have sold property to get income to keep him in a nursing home?

Mrs. **Welborn**. No, sir. We sold it before he went into the nursing home but that was our income and it will soon be paid out. In fact, in a couple of years the property will be paid out because what we have lived off of in addition to our savings, that is what we planned on living on through our golden years, but the illness that we have both had has taken its toll on us.

Senator **Sasser**. Are you going to have enough income left from the sale of this property and savings to keep him in the nursing home?

Mrs. **Welborn**. No.

Senator **Sasser**. So you are going to have to exhaust all of your assets and then I assume you will go to Medicaid——

Mrs. **Welborn**. Yes, sir.

Senator **Sasser** [continuing]. To get assistance to keep him in a nursing home,

Mrs. Welborn. I'll have to.

Senator **Sasser**. Mrs. Welborn, what will happen to you in the interim?

Mrs. **Welborn**. That is what I'll live with day by day; I wonder. I just live one day at a time.

Senator **Sasser**. You and your husband thought that you had planned ahead. You had worked all of your life in your own business and you had set aside enough money that you thought would care for you adequately in your golden years?

Mrs. **Welborn**. Yes, sir.

Senator **Sasser**. You had planned ahead and you had Medicare coverage and Blue Cross coverage and you had gotten additional coverage through AARP and after all of that hard work and after all of that planning, you now find that you're going to have to spend everything to get Medicaid money to keep him in a nursing home and you are left, I'm sure, with great anxiety as to how you're going to care for yourself in the years to come.

Mrs. **Welborn**. Yes, sir.

Senator **Sasser**. That's the point I want to make. If that is the system we have presently in place in caring for the health care needs of the elderly people in this country, then it is a defective system——

Mrs. **Welborn**. Yes, sir.

Senator **Sasser** [continuing]. Because you and your husband have done everything that anyone could reasonably expect you to do or you have done everything that you could to reasonably anticipate the problems that you might encounter later in life, and through no fault of yours and through no failure of advanced planning, you now find yourself because of tragic circumstances, in a tragic circumstance.

Mrs. **Welborn**. Yes, sir.

Senator **Sasser**. And listening to you, I assume there is nothing that you and your husband could have done to avoid the financial problems that you are presently encountering.

Mrs. **Welborn**. No.

Senator **Sasser**. Thank you very much, Mrs. Welborn. And I think your case illustrates very graphically why we need to have some legislation that will deal with the long-term health care needs of our elderly population.

Ms. Nichols, I would like to turn to you now and we would like to have your statement again. We have heard it but we want others to hear it so if you would be good enough to let us hear your statement, then we will have questions we would like to ask.

TESTIMONY OF MARGIE NICHOLS, NEWS REPORTER AND PRODUCER, WSMV, NASHVILLE, TN

Ms. **Nichols**. Today I will share with you research that we gathered as the result of a series produced at WSMV in Nashville. The research was on Medicare supplemental insurance and abuses in the sale of this insurance which is commonly called medigap insurance. In doing the series, I had the opportunity to talk with many senior citizens about their experiences with medigap insurance and primarily the experiences they had when salesmen came into their home to sell this insurance. Most of these people had a story to tell and it's often a very sad story about unscrupulous salespersons whose major concern is to make a sale.

I also reviewed numerous complaints at the State Insurance Department, complaints from senior citizens who felt like they were treated unfairly by these salesmen. In addition to this, we conducted our own investigation. We used a hidden camera and secretly videotaped actual sales presentations made by these salesmen. We videotaped four people. Three of the four misrepresented their policies and used unfair tactics, according to a consumer advocate with the Department of Insurance whom we had review the tapes. The tactics that they used included scare tactics, high pressure and intimidation. In an effort to make a sale, some agents went so far as to misrepresent their policies of their company, and others just out and out lied about what their company will cover or they lied about another company's policy to get someone to buy their own.

The agents are often very nice, they're quite charming and flattering but if this doesn't seem to be working for them, you can instantly see them shift gears and start using scare tactics and intimidation, anything to make a sale. Many senior citizens told me that they felt like they had to buy these policies just to get the salesmen out of their home. It's been known that these people would stay three or four or even five hours in someone's home, just continually pressuring them to buy this insurance. For instance, one agent used the phrase, "You're not going to have me drive all the way down here and not buy this, are you?" And this is after the woman had already told the agent she didn't want him coming to her home in the first place.

Another agent told an 86-year-old woman that her insurance company was going out of business. It frightened her so much that she immediately wrote out a check for $804 which was 2 months' income for her just to make sure she had coverage. The truth was, her policy was perfectly good, it was in force for at least 6 more months, and the company was not going out of business. The other agent used this just to make a sale and just to get a profit for himself. A 90 year-old woman was forced to go on food stamps because an agent who had been calling on her for 4 years suddenly sold her a large amount of insurance that cost her well over $1,000. She had $72 left in her checking account to live on for a month and she was forced to go on food stamps just so she could have food for that month, and to top it all off, she didn't need any kind of insurance because her income was so low that she qualified for the State Medicaid program.

This same agent that sold her all this insurance sold another woman $2,000 worth of insurance. The woman had no running water, she had no bathroom in her house and she also qualified for Medicaid but she made out a huge payment of everything she had for him. This same agent has a history of doing business this way. There is documentation to show of other complaints against him going back at least to 1980.

Senior citizens are afraid of high health care costs. They are afraid of sticking their families with the bills. That is what makes them vulnerable to these salesmen. These ladies were talking about nursing home insurance and that is one of the biggest selling points that we saw in the video tape and we have actual tapes of at least two agents saying, "Oh, yes, this will cover nursing home." In truth, it does cover nursing home, skilled nursing home, which 14 percent of the beds in Tennessee are skilled homes. It doesn't cover convalescent or intermediate care, but they don't tell these people the difference and when you think of a nursing home, you think of—It's generally what we think of as an intermediate or convalescent care home. They never say this is only a skilled home. They just say, "Oh, yes, this covers your nursing home cost." So that's part of the problem. They are being told that it does and if you read the policy, it really doesn't.

The two biggest problems we saw were agents who say the policy will cover everything. They never go into the exclusions of a policy, the things that it doesn't cover. They just say "This will cover everything," and agents that try to roll business or twist business, which is, if an elderly person already has an insurance policy, they go in and say "You need to buy my policy" and they give them several reasons why it's better.

Many of the policies are virtually the same and the bad part for the senior citizen is that it's a 6-month exclusion on a new policy when you're not covered for anything you've ever had before. The reason the agents do this is because the first year commission is 60 percent, and they work for many different companies, they can sell many different policies, so if they sell a different policy to the same person every year, they get that 60 percent commission every year and leave the elderly person with sometimes no insurance and themselves with a hefty commission. One agent was literally stealing money from senior citizens. He had them make out a check to what they thought was a company. It was initials and it was called C.T.C. Corporation—and he's not alone, it happens with many, and the initials just happened to be his own. He cashed the check himself, pocketed the money, never sent them a policy. They had no coverage and didn't know it until they would think, where is my policy. He was later arrested and charged, but they had no reason to be suspicious of him because he had a license to sell insurance and he had information from a legitimate company.

It all becomes very confusing because senior citizens just didn't know who was telling them the truth because they have so many people coming to their door wanting to sell them something. The most outrageous thing that we heard over the course of the video tapes was an agent who went into a woman's home, and we actually had a tape of this, and looked around the home and could tell that she was a very religious woman, so he sat down and said to her, "God sent me today and that's why you should buy this insurance policy from me." They use all these tactics to intimidate. They intimidate the elderly, they scare them, and they exploit the fears that the elderly already have about health care costs.

Senator SASSER. Thank you, Ms. Nichols. Let me ask you this question. If we had an aggressive national and state public service advertising campaign directed at senior citizens telling them about medigap insurance and combined this with a national or a state toll free hotline giving senior citizens advise about these medigap policies, do you think that would be helpful in keeping our senior citizens from buying these defective insurance policies?

Ms. NICHOLS. I think education is the most important thing. After our series ran, I got calls from several insurance agents going, "Gosh, these people are asking me so many questions now because you put this on T.V." There's nothing wrong with that. I think education is the key to knowing that, no, my insurance policy does not cover intermediate care nursing homes, and if the elderly know that—I think it would help. It's so confusing when you have someone in your home, and you have no reason not to believe these people on the front end, but it still becomes confusing when you don't know what they are talking about. The more education and the more we teach the elderly about what the policy will actually cover, the better off they will be.

Senator SASSER. I was just reading in the paper here yesterday there was a report on a survey which was done by the Tennessee Health Care Association. I don't know if you are familiar with that or not, but it indicated that the greatest fear that older people have, is that they might end up in a nursing home and they worry about the cost of it. Eighty-five percent of the people who were surveyed indicated that they never wanted to go to a nursing home, yet that fear is there and that they are going to go, so they seek to purchase insurance policies that would pay for this nursing home care that they think may come even though they hope they never have to go.

You did a great public service in your media market area by exposing this whole problem and my guess is that you saved literally thousands of elderly people in the Nashville, North Tennessee, Southern Kentucky area from being exploited by these unscrupulous medigap policy salesmen, but I do think that we need to direct our attention now at trying to get that information out in a more systematic way and perhaps public service advertising and a toll free hotline maintained by the Department of Health and Human Services in Washington and the Department of Insurance here in the State of Tennessee might be a way of dealing with that problem of these salesmen who exploit the fears of elderly people.

Ms. NICHOLS. I think television is a real way to reach these people because the problem exists, it's more prevalent in rural areas of Tennessee.

Senator SASSER. Why is it more prevalent in rural areas?

Ms. NICHOLS. Many of the companies are based, for example, in Nashville or Memphis but they will literally send agents into a small town, put them up in a hotel and they just canvass the area. I don't know why. I think perhaps they are a less sophisticated audience, and they don't know how to complain or where to go to complain or where to go get help.

There are perhaps more people living alone—I don't know why but from my experience, the people that I've talked to and the people who have written complaints, almost all of them are from small towns. Many that I talked to are from small towns around Nashville and they are not far away from the city but perhaps people go back home to live when they get older, I don't know. I can't answer really why but I know that it seems to be happening more often in small towns.

Senator SASSER. Thank you very much. I want to thank all three of you for your appearance here this morning and all three of you for your testimony. It was very, very valuable.

For our next panel of witnesses we will hear from Mr. Gene Holcomb, if you will come forward, Mr. Holcomb, and Mr. Lanny Bruce. Let me just by way of introduction to our audience here, Mr. Holcomb is with Blue Cross/Blue Shield. He is a graduate of Mississippi State University and is the Vice President of the Finance and Claims Division of Blue Cross/Blue Shield. Mr. Holcomb is also President of their affiliate, the Southern Health Plan, the largest health maintenance organization in the South. Our other witness is Mr. Lanny Bruce of Memphis. Mr. Bruce has a B.S. from the University of South Connecticut and he is the Vice President of Health Services for Senior Citizens, Incorporated. He is responsible for the homemaker program, the medical transportation program and the Medicaid Waiver Program. Gentlemen, I want to express my appreciation to both of you for appearing here this morning and we will begin in reverse alphabetical order with you, Mr. Holcomb. You have a statement.

TESTIMONY OF GENE HOLCOMB, BLUE CROSS/BLUE SHIELD, MEMPHIS, TN [2]

Mr. HOLCOMB. Thank you, Senator. As you have indicated, I'm Gene Holcomb, chief financial officer for Blue Cross/Blue Shield of Memphis and President of Southern Health Plan, Tennessee's largest health maintenance organization. I'm a certified public accountant, and I have had experience with the Medicare Program since its inception.

Our organizations currently provide medigap coverage to an estimated 22 percent of the Memphis Area beneficiaries and we serve as Part A intermediaries to Medicare. Additionally, we also insure or administer the insurance for over 300,000 Memphians under age 65.

We do not market medigap aggressively. Most of our references are by phone or walk-in to us. We do not do door-to-door marketing nor do we have heavy advertising campaigns, et cetera. We market the product very passively, and basically, we lose money on the product. Our targeted loss ratio for the product is 83 percent. Our administrative costs for the product is a reciprocal 17 percent and we have been unable to achieve the targeted loss ratio consistently over the years. We currently charge a little less than $36 per month for our medigap policy. We do have a rate increase on file with the Department of Insurance pending their approval.

We applaud your concern for protecting the elderly from financially catastrophic health costs while desiring to insure that every American has ready access to quality health care. I wish to make it abundantly clear without the need for repeated reiteration during my comments that we are in absolute support and sympathy for your goals. Any seemingly negative comments that I might make are purely out of concern for the economic aspects of the proposals because we believe that the availability of health care services very clearly breeds demand for these services and cost overruns are very frequent.

We also support the notion of free enterprise where appropriate and possible. The intent of medigap policies has often been misunderstood. Most companies offering medigap policies intended from the start to supplement Medicare by covering the gaps or the holes, coinsurance deduct and other features of basically services that were covered, that were covered benefits of Medicare. Very few of these policies ever intended to offer supplemental benefits of a nature that were not essentially covered by Medicare and that has been a source of great confusion and understandably so. It also has been a source of some inexcusable sales tactics which we certainly abhor.

However, the private medigap market has in general, in our opinion, adequately protected the majority of beneficiaries who have elected to purchase or who can afford to purchase such supplemental coverage for acute illnesses. However, the vast majority of medigap policies essentially pay only Medicare coinsurance and deductible amounts plus extend the lifetime maximum of days usually by 365 and pay 20 percent of the physician's approved charges,

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[2] See p. 171 for Mr. Holcomb's prepared statement.

20 percent of home health and other related items like durable medical equipment, et cetera. Most often, I reiterate, no coverage is afforded for services not of a nature and type covered by Medicare.

Unfortunately, many beneficiaries choose to purchase multiple medigap policies which often is not cost effective because whereas we charge a little less than $36 a month, if they purchase AARP and many other policies, they can run up these enormous annual bills for medigap and it is not a cost-effective purchase. Their fear of becoming insolvent because of health care costs, of course, is their motivation in duplicate coverages.

The major need in the acute care catastrophic coverage arena is meeting the needs of beneficiaries without the private supplemental coverage because they can't afford it or don't choose to buy it. We believe that approximately one-third of the Medicare eligibles don't have it. The most prevalent expense incurred by beneficiaries which is not usually catastrophic in nature is the difference between Medicare approved physician charges and the physician's actual charge, and of course, Medicare pays on the basis of 80 percent of their approved charge, and there is often as much as 40 or 50 percent difference between what Medicare approved and what the physicians actually charge. Very few physicians in the Memphis area take assignment.

The single greatest overall financial risk to the elderly, of course, is long-term care, and long-term, non-acute custodial care which is a primary purpose of this hearing. We certainly support addressing that risk. We would hope that some type of plan could be explored and devised to in some manner utilize the private sector in partnership with Government to this end.

We oppose taxing Medicare in any manner to fund new benefits, and we believe that any new funding mechanism should not disadvantage the low income beneficiaries. The effect of Medicare cost shifting to the private sector is real and is currently being funded by corporate America and the American citizens who pay for insurance coverage and we oppose any further restrictions or unrealistic cutbacks of Medicare which would result in additional costs shifting to the private sector.

We believe that expanding Medicare to include out-patient prescription drugs would be unduly expensive and promote excessive utilization without significantly increasing the quality of care. We are aware that many prescriptions go unfilled and many prescriptions go untaken at present, but we believe that a significant drug program paying for these drugs would cause runaway utilization of prescription pharmacy items.

Although we do believe that prescription drugs are certainly a significant out-of-pocket expense to many beneficiaries, we also believe that that cost should not be an unreasonable burden except to the lower income individuals and we would prefer that that issue be addressed by a program of assistance to those specific individuals who might need help in paying for their prescription drugs. We think that would be a more cost-effective overall approach.

We believe that the current restrictions on inpatient and outpatient mental health benefits under Medicare should be lessened or removed but only with special emphasis on utilization review programs to avoid abuse in excessive utilization in that area. Currently, Medicare limits lifetime mental health inpatient days to 190 and outpatient expenses to $250 per year with 50 percent co-payments. Although these maximums affect relatively few individuals, at least 10,000 nationally have exhausted their inpatient benefits and this certainly is a catastrophic situation for those few individuals.

There has been periodic discussion as presented by Ms. Nichols about misleading advertising and marketing practices in the commercial medigap market. We certainly do not deny that that exists. Such practices are abhorrent, usually illegal, and are not condoned by any reputable companies.

The National Association of Insurance Commissioners NAIC has already released an exposure draft of the new model advertising and marketing regulation for medigap and is currently developing a revised minimum Medicare supplement standard model regulation. We support the work of the NAIC. Most states usually ultimately adopt the recommendations of the NAIC either by adopting their model regulations per se or by embracing the intent embodied in their models. I have provided your staff with a copy of my prepared statement, and that concludes my comments.

Senator SASSER. Thank you very much and we will turn now to you, Mr. Bruce for any statement or comments that you wish to make and then I will have some questions.

TESTIMONY OF LANNY BRUCE, DIRECTOR OF SENIOR CITIZENS SERVICES OF MEMPHIS

Mr. BRUCE. Thank you, Senator. First, I would like to tell you a little bit about what we do at Senior Citizens. Senior Citizens Services primarily have been involved with senior citizens for the past 25 years. We are involved in senior employment programs, senior training programs, and we also have a homemaker program and we have traditional health services as well.

In addition to our traditional health services, we are involved with a Medicaid Waiver Program that provides ICF level care to patients in their own home. The reason I wanted to state that first is that a lot of this discussion centers around medigap policies. We don't have a lot of experience with medigap policies as senior citizens and there is a good reason for that. Most of them don't cover the kind of services that we offer, and the services that we offer are for people who have long-term needs that need in-home care, and most of these medigap type policies do not extend the care in the homes. They don't give patients or clients, however you want to describe them, the option of remaining in their own home and thus maintaining a psychological benefit of being treated in familiar and comfortable surroundings.

In looking through some of the material before I came today, I read through a lot of legislation, news articles and so forth.

First, the House bill that was just recently passed when the Congress was in session, that's going in the right direction. It keeps the out-of-pocket expenses to a reasonable level. It increases the skilled nursing home days from 100 to 150 with a significant reduction in the co-payment, and it does include provision for long-term care. It does slightly increase the home health benefits. All of this is only a modest increase in the Part B Medicare premium.

You notice I didn't mention ICF level care, Intermediate Convalescent Nursing Home Care, which I think is one of the greatest needs of the elderly today. Not everyone is going to require skilled nursing home care. Even the ones that do, the number of days that are paid for in Medicare are very limited.

I believe that the Government could best address elderly health care by increasing in-home program benefits, allowing the elderly the option of remaining in their own homes, increasing the participation in programs like health maintenance organizations, competitive medical programs much like the waiver program that we administer through the State Department of Medicare. You are probably familiar with it as the 2176 waiver, which is, in fact, an ICF without walls.

We provide ICF level care to patients in their own homes and I would like to also add that we do that more cost effectively. Currently, the ICF level caps or the maximum cost in Tennessee is between $33 and $35 per day. We are able to provide similar level care in a patient's home for half of that.

The other problem that I see in the current way that Medicare is structured is the overemphasis on the administration of the program. You talked before about 94 cents out of every dollar goes to hospital care.

Senator **Sasser**. And physicians' bills.

Mr. **Bruce**. And physicians' bills.

Senator **Sasser**. Physician fees and hospital bills, 94 cents out of every dollar.

Mr. **Bruce**. And only 1 percent goes to long-term care.

Senator **Sasser**. Right.

Mr. **Bruce**. I am making the assumption that that dollar that you're talking about is for direct service dollar and I have to question how many dollars that are appropriated directly to Medicare go to Medicare administration and then what percentage of those dollars actually make it into direct service for patients. There is a big hierarchy in Washington and there are regional offices and there are State offices that a lot of those dollars have to pay for in the administration of those programs, and I have to question if there is not fat in that administrative process.

The other thing that we have talked about this morning is that in order for patients to get the kind of care that they need, particularly in the long-term setting is that they have to sell their homes, they have to exhaust their savings, they have to sell what little stocks or bonds or whatever they might have in order to become eligible for Medicaid. Bear in mind that Medicaid does provide a lot of coverage for the elderly and poor, but there is also a lot of things that Medicaid doesn't cover as well. Medicaid is not the end all and do all for long-term care for these people. I think for us to assume that once they spend all of their resources down to the point where they are eligible for Medicaid that then all their needs are met you should not be left with that impression. That certainly is not the case.

Again, I think that the key to reducing the unnecessary expense of these medigap policies that are just not working, and they are not providing the coverage they have as Ms. Nichols has said, is by education. Whether that should be through public service announcements or brochures going out to the elderly or whatever, I think that is a pressing need.

Most elderly, in fact I can think of my own parents, for years prior administrations boasted of the proudness of Medicare would take care of them in their old age when you and I and everybody else knows that that is not the case. Then medigap policies come along and proudly state that for a premium of X number of dollars a month, it will fill in those needs, and the elderly believe these people. So it is an educational effort that needs be done.

But again, I would just like to emphasize that in addition to looking for direct payments through Medicare through whatever financing or funding mechanism for long-term care, let's not also leave out that option of caring for people in their own homes. A number of elderly people can be properly cared for in their own homes. As we are looking at revising Medicare regulations and standards, let's look at quality assurance and taking care of people's needs and not worry so much about crossing the T's and dotting the I's. Thank you.

Senator SASSER. Thank you, Mr. Bruce, and I couldn't agree with you more about home health care. I'm a very strong advocate of people being cared for in their own homes if there is any possible way that can be done. I think generally speaking, that is a more cost-efficient way of approaching the whole problem.

Mr. Holcomb, as I'm sure you know in your experience with Blue Cross, more than two-thirds of the elderly purchase supplemental insurance policies. These medigap policies are supposed to cover the amount that Medicare does not pay, and yet reports show that many of these commercial insurers are still selling policies that return 60 cents or less in benefits for every premium dollar that is paid in by way of premiums. Now the average return on health insurance policies as I'm sure you know is close to 90 cents on each dollar. Should the 60 percent minimum return on medigap policies be raised in your judgment and what is the experience with Blue Cross/Blue Shield? I think you have told us that you lose money on your medigap policies.

Mr. HOLCOMB. Yes, Senator, that's correct. Historically, we do lose money on our medigap policies. As I stated earlier, our cost of administering our medigap program is 17 percent so we shoot for 83 percent loss ratio which we have been unable to consistently achieve over the years. That would compare with our overall administrative cost of only 8 percent. The differential being that though we do not spend a lot of money advertising and marketing medigap, servicing these people is a tremendous problem because they do not understand the policies easily, and it requires a lot more time explaining the benefits and explaining why certain things are and are not covered. It is a very labor-intensive policy.

We have historically been a not-for-profit organization, as you well know. We are now subject to Federal taxation, and our views are perhaps slightly different than they have been historically. However, even as a taxpaying entity, I would suggest that 60 percent loss ratios are too low, that certainly a building in of a profit margin that is seventy percent might be a more realistic figure for a commercial entity with stockholders that are looking for a return on investment.

Senator SASSER. The medigap policies that you sell, they don't cover long-term health care, do they?

Mr. HOLCOMB. No, sir, they don't, and that is a very misunderstood item. Again, Ms. Nichols addressed that some-what. Hopefully, we don't have salesmen who are misrepresenting that. We have had very few complaints and we would not tolerate that type of misrepresentation. However, people do confuse the fact that we pay the $65 co-pay on skilled nursing care from the 21 through the 100th day, so we do have a skilled nursing facility benefit in our medigap policy.

What they do not understand is that Medicare and consequently most medigap policies including ours provide no coverage for care that is custodial or not medically necessary. Since most nursing home care that is being afforded does not fall under the covered benefit provisions, so very little services are being rendered that would qualify for payment under medigap.

There are other areas of confusion as well. The home care area, private duty nursing, those types of things also are very confusing. Private duty nursing is afforded as a benefit in many of these policies including ours but only when medically necessary and very rarely is private duty nursing deemed to be medically necessary so it's a very confusing item.

We would certainly agree that a very aggressive posture of public education about medigap policies would be very productive and in the interest of the public.

Senator SASSER. If I am not mistaken, there are one or two companies that do sell policies that cover long-term health care needs, aren't there?

Mr. HOLCOMB. That is correct. I don't want to suggest that there haven't been companies around for a long time that have not, but it is an area that is receiving increasing interest, and more companies are getting into that type of business. However, Senator, I would relate the long-term policies as being more like a pension program, an annuity or a life insurance program than a health insurance program.

Senator SASSER. How much do those policies cost?

Mr. HOLCOMB. I do not know. We do not offer such a program.

Senator SASSER. You don't have a ballpark figure as to what the premiums are on these policies?

Mr. HOLCOMB. I do not know.

Senator SASSER. I've taken testimony before or read somewhere the cost of them. I forget precisely, but they are, as I recall, very expensive.

Mr. HOLCOMB. Yes, they are. You are insuring against a risk that is certain to happen. A high degree of people are going to use this product when they qualify because of age. Very few are going to pay for it and then not use it so in effect, some of these are a gamble against whether these people are going to be fortunate enough to live to the age that they will use it. They know very few people will forego the benefit, so it is indeed a form of annuity, in my judgment.

Senator SASSER. I am reminded by staff that the premiums on these policies which do indeed afford long-term health care are somewhere in the neighborhood of $2,000 a year. Is somebody saying "no" back there?

Mr. COLEMAN. The cheapest one that is on the street right now will run anywhere from $50 to $80 a month, but the benefit period, Senator, is only for two years.

Senator SASSER. Would you identify yourself, sir, for the record?

Mr. COLEMAN. My name is Bob Coleman and I am the health care consultant to the Regional Medical Center in Memphis.

Senator SASSER. Let me ask you one final question, Mr. Holcomb. Based on your professional experience with Blue Cross, do you think that private insurance policies will be able to fully cover the coverage gaps that are left by Medicare, especially long-term care for individuals at all income levels?

Mr. HOLCOMB. No.

Senator SASSER. I don't think so either. And I don't know of any unbiased observer either in or out of the insurance industry who thinks so either as a matter of fact.

Mr. Bruce, in your view, what is the single biggest problem with regard to health care needs that the senior citizens that you come in contact with are facing today?

Mr. BRUCE. I guess I would have to say access to that care either because of economic, financial limitations or other limitations. They just don't have the access to the care. One other thing that I wanted to say about Medicaid, for instance, is that there is a very limited number of beds in Shelby County that are dedicated to Medicaid recipients. A nursing home owner, if it's a private home, for instance, who can charge patients $65 a day, has no incentive to have Medicaid beds when Medicaid is reimbursing at $37 a day. It doesn't take a financial wizard like Mr. Holcomb here to figure out that they are going to lose money doing that—no incentive.

Senator SASSER. In your job as Vice President of Health Services and as Director of Senior Citizens Services, do you have contact with many older people who are in need of long-term care services?

Mr. BRUCE. Just in two of my primary programs, we have about 500 people in our homemaker program and about 125 our ICF level in-home program.

Senator SASSER. So do you have an opinion as to whether or not we need to restructure the Medicare system in order to handle these long-term care needs?

Mr. BRUCE. Yes. I'm bad to use examples, but If you were in a car wreck, you wouldn't want somebody to put a bandaid on a gaping wound. I think that looking at the Medicare system from my perspective, that program has had a car wreck, and an approach to patching up the holes in the sieve with a bandaid is not going to be sufficient to meet the needs of the elderly and for sure not in this community.

Senator SASSER. I couldn't agree with you more. I think what needs to be done about meeting the health care needs of the elderly in this country is going to be one of the most overriding—will be the overriding issue—perhaps, of the decade of the 1990's. Gentlemen, thank you very much for appearing here this morning and giving us the benefit of your views. We appreciate it.

Our next panel will consist of Dr. William Applegate, geriatric specialist, and Mr. James Brown, a nursing home administrator and I'm going to say more about these two gentlemen. First, Dr. Applegate is from Memphis. He is a professor of medicine and preventive medicine at Methodist Hospital right here in Memphis——

Dr. APPLEGATE. I must correct you. I am basically at the University of Tennessee. I really don't have too much affiliation with the Methodist although I do work with them a bit.

Senator SASSER. We need to get you affiliated even more out there. As I understand it, you are the chief of the Division of Geriatric Medicine and also a member of the American Geriatric Society Dr. Applegate is joined by Mr. James Brown, and Mr. Brown is the chief administrator of Oakville and Shelby County Nursing Homes. He is retired from the Navy Medical Service Corps and also served as President of the Tennessee Health Care Association. I want to thank you, Mr. Brown, for allowing us the use of your facilities here today at Oakville. Dr. Applegate, we will start in alphabetical order and start with you first. Dr. Applegate, do you have an opening statement?

TESTIMONY OF WILLIAM APPLEGATE, M.D., GERIATRIC SPECIALIST, MEMPHIS, TN [3]

Dr. APPLEGATE. We are all aware, Senator, that the population in the United States is aging and sometime around the year 2000, 17 percent of the population will be over the age of 65. Currently, elderly people consume between 24 and 26 percent of the United States' total health care expenditures, and it is projected that in the year 2010 that older people will consume as you know about 46 percent of the American health care dollar.

Just a few projections to give people an idea of the impact of what we are talking about with our aging population. Physician visits by the elderly are going to go up at least 40 percent by the year 2000 and may be even more with the relative surplus of extra physicians currently trained. Acute care hospital bed days will probably level off for a period of time but will escalate again by the end of the century. Nursing home bed day utilization will increase at least by two-thirds by the year 2000 to 2010, and the number of frail, home-bound elderly people in this country will double in the next 20 to 30 years. That will have a tremendous impact on both our health care and social systems, and I question whether we are prepared to meet this onslaught of need.

How well is the medical care system prepared to meet this need? There are a number of concerns that I have. As you know, there are very few physicians today trained specifically in geriatric medicine, and we estimate that by the year 2000, that we have to train at least 2,000 more geriatricians, that is, physicians who specialize in geriatric medicine if we are to begin to fill the need we have for academic slots and maybe a few extra slots in health care corporations and private practice settings, and that 2,000 is really probably an underestimate of the number we need.

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[3] See p. 176 for Dr. Applegate's prepared statement.

The American Geriatric Society has recommended there be five M.D. faculties specializing in geriatrics in every medical school in the country by the year 2000. We are currently training in this country around a hundred geriatric specialists or people with geriatric focus per year, and that number per year will in no way meet the demand that I'm describing.

We all assume that the majority of health care for older people will continue to be delivered by primary care physicians, family physicians and internists who are already in the community. There is a tremendous need for continuing educa-tion, as new concepts about the care of the elderly are emerging, these concepts need to be disseminated to people that are already out in the field practicing medicine.

Unfortunately, medicine in recent years has had an extensive disease oriented to high technology sort of approach and focus, and this approach and focus does not lend itself very well to specific care of frail, elderly people.

As you yourself alluded to earlier, Senator, the older person often presents with complex medical problems that require the balancing of therapies, oftentimes one against the other and require the physician to consider issues of emotional or psychiatric state, family well-being, economic resources, et cetera and we simply have not trained physicians to this date to begin to be able to either consider or balance these multiple factors. Nor have we trained physicians adequately to deal with a number of special problems that elderly people have like Alzheimer's Disease, Parkinson's Disease, stroke, and the like.

To address these burgeoning sort of health care problems, I think there are two basic paths we must take to solve our dilemma with regard to having the medical care profession well-prepared to handle this increasing demand for care for the elderly. First of all, I think we need to upgrade the quantity and quality of health professionals who are specifically trained in the health care problems and who are to bring service to the health care needs of the elderly.

I applaud your efforts in your bill. I agree with you that the first step is to focus on training and research. We need in our medical schools more talented academic leaders to serve as role models to attract young students and young physicians in training into the field. Without these exciting role models, we are not going to be able to reverse the trend you have already described where only 4 percent of medical students in the country are currently taking electives in geriatric medicine. But even as important as role models are, we also need academic leaders who are going to do research. Research in the health problems of older people has gotten a bit of short shrift in years past.

If you look at the funding from the National Institutes of Health, there has been a recent upsurge in funding for the National Institute on Aging, but aging-related health problems have not gotten the input of dollars that other health care problems for the middle-aged and younger persons has gotten classically in the past. We need that body of researchers to really explore some very basic and fundamental questions about treating common illnesses in the elderly like dementia and like Parkinson's Disease, like strokes, like hip fractures. There are all kinds of basic issues that need research and we need to build that body of knowledge so that the field will grow.

I have already given you my projections about the conservative estimate for the number of geriatricians we will need in the future. I want to say I'm very supportive of your new legislation and most of us that are active in the field see this as a giant step forward and are frankly very appreciative. I have one suggestion with regard to your legislation. If your legislation were passed and were to create 5 to 10 geriatric centers of excellence, I do have a concern that centers of excellence have a tendency to train people, excellent people who remain in close geographic proximity to the center of excellence.

I was trained myself as a Robertwood Johnson Clinical Scholar and as the Robertwood Johnson Foundation is fond of saying, they are very proud of their program, but the program has done the most for the centers that train the scholars and that the scholars tended to stay near the home institutions. The greatest predictor of where a physician will settle for practice or for his future academic life is actually where he did his last bit of training, so I'm a bit concerned and I wonder if part of the initial monies for centers of excellence could be redistributed for a sort of planning start-up rule so that other centers that were approaching the center of excellence critical mass but not there yet could get some planning and start-up, sort of short-term grants to see if they could get over the hump for a future sort of competition for a center of excellence award.

I think spreading a smaller amount of money across a larger number of centers would have a great stimulus effect on the field. A few years ago the National Institute on Aging gave very small grants to medical schools to develop initial curricula in geriatric medicine. The initial awards were modest, but there was a great deal of flurry of activity. As you know, we academicians respond to even the possibility of money with a flurry of activity and planning for the future and so I have that one suggestion with regard to the bill.

Earlier I stated that for medicine to be prepared for the geriatric imperative not only are there training issues but there are issues in the organization and financing of health care and I would just like to give my academic physician's perspective.

The first observation I have to make in this regard is that the history of Medicare really indicates that Medicare has acted as a stimulus to both price inflation and the provision of excessive amounts of high technology care. I am not saying that Medicare is not a good thing.

I think Medicare was a wonderful bill and provided needed service to countless millions of elderly people. But it was predicted before Medicare was finally passed that the compromises that were reached on the House and Senate floor, it was predicted that the way the fee schedules were set up with Medicare and the way the system of third party reimbursement was structured to feed into fee for services system it was predicted from the outset by people that were experts in the field that Medicare would be highly inflationary and that the great bulk of the money would act as a stimulus to development of a hospital sector and to the development of high technology specialties where the relative value scale is such that there is a greater compensation for high technology procedures. What I'm trying to say is that quite frankly, in American medicine as in many walks of American life, what you pay for is what you get, and the system we have today is a system that we have helped restructure through financial incentives like the Medicare program.

What recommendations then do I have? First, I agree with your observation and the observation of others who have testified here that one of the greatest pressing needs in terms of financing is long-term care for the elderly. I am aware of some of the grave sort of economic difficulties with funding long-term care in the elderly and one of the things that I would personally propose is that Medicare and acute hospital care financing mechanisms and long-term care of mechanisms be combined under one national program.

I believe that the acute care hospital sector and the sub-specialty high technology sectors of American medicine are bloated. I think that they consume excessive amounts of resources that are not driven totally by patient need. I think they are driven in part simply by financial reimbursement system, and I think there are substantial numbers of dollars there that could be redistributed to long-term care.

So I have said the most pressing issue in my mind for care of the elderly is long-term care and not catastrophic care. I will say parenthetically that I think catastrophic care is a nice idea. It is not going to benefit a huge number of elderly people.

Senator SASSER. It costs a lot less than long-term care so it makes it politically attractive to——

Dr. APPLEGATE. That is absolutely—I've got your point and you are right on the mark so that is all I can say about that, you got me. In order to achieve a more rational system of reimbursement for care for the elderly, the following components of reimbursement system are needed over the long term, in my opinion.

One, capitation payment for all health care for the elderly, not just say that co-payments and deductibles would not still be a necessity.

Two, radical restructuring of fee and reimbursement schedules for both physicians and hospital charges.

Three, national integration of payment for acute care and long-term care into one national reimbursement system.

Four, distribution of resources for frail and high-risk elderly based on a case management system that planned and distributed resources not simply according to the needs and demands of the health care system but takes into concern some of the social and home care needs of the elderly as well.

That is my statement. Thank you for asking me to come.

Senator SASSER. Thank you very much, Dr. Applegate. Let me ask you a couple of questions here. Number one, we don't have many geriatricians in this country. What attracted you to this specialty?

Dr. APPLEGATE. Somebody offered me a job, I needed to make a living so I came to the University of Tennessee. I guess I was attracted for two reasons, Senator. I've always been interested in older people and have always found my practice gravitating toward older people. I was trained both in internal medicine, public health and epidemiology and I've always gravitated toward issues in medicine that I thought were major societal issues. It was my feeling when I left training that one of the major issues in American medicine that would have to be faced by the turn of the century were the health care needs of the elderly, and since I'm oriented to public policy and social issues and I like older people, I decided geriatric medicine was a good profession for me and I needed a job.

Senator SASSER. Have you written very extensively on this whole subject of treating elderly people or what you anticipate in the future with regard to the demand on the health care system with regard to treating elderly people? Have you written anything about that?

Dr. APPLEGATE. I've written a fair amount. Early in my career I focused more on cost containment research and how one influences physician behavior and had a number of publications in the area. I have written a bit about the problems with technology and reimbursement, but recently, most of my articles have been really addressing sort of clinical care issues in the elderly. I do two types of research. I do research on hypertension, clinical problems in the elderly, and I do research in health services research which looks at the impact of the way we structured health care on health outcomes in the elderly. So I have written in the area but not a lot around the specific areas of this particular testimony today.

Senator SASSER. I would be interested in reading your articles on hospital cost containment. When did you write those?

Dr. APPLEGATE. Most of the articles that I wrote on cost containment were written between about 1979 and about 1983. I would be glad to send them to you.

Senator SASSER. I would appreciate that. Tell us just some of the ways in which treating an elderly patient is different from treating, say, an acute care patient.

Dr. APPLEGATE. First of all, as any of us age, the probability of developing chronic diseases goes up. Now older people tend to have multiple chronic diseases and although they may have an acute sort of problem and need temporary hospitalization, just because that acute problem gets somewhat better, that chronic disease doesn't go away. The special attributes of care for the elderly, as I said before, are you have to balance out the treatment for these various chronic diseases. You have to then integrate also issues with regard to emotional health of the individual, the support that is available for the individual, both informal support systems like the family and formal support systems like Senior Citizens Services which has been mentioned here today. Then there has to be knowledge of all these factors and integration. There has to be specific understanding and knowledge about a variety of diseases that are just not well-covered in medical school.

When I was in medical school and in training, I never got any training on dementia, got very little training on Parkinson's Disease, I got very little training on gait problems, mobility, incontinence, all the things that older people have with a fair amount of prevalence. Basically, it's really handling the complexities of the patient with multiple problems who is frail.

Geriatricians, by the way, tend to focus on the "old-olds," I'm sure you know, people well past aged 75 and we tend to focus on the most frail elderly people who have several diseases where you have a balance out a lot of things, where the diseases aren't going to go away at the end of the hospitalization. There needs to be continuing care in a variety of support services available to support that person in the community and outside of an institution.

Senator Sasser. Are there other countries where there is more intense interest in geriatrics? For example, I was in the Soviet Union a couple of years ago and encountered a lot of Soviet geriatricians. Most of them are studying very old people in Georgia that live to be 110 and 120 years old, or at least they claim to be that old. I came away from there with the impression that perhaps we were behind the Soviets considerably in the field of geriatrics.

Dr. Applegate. To be honest with you, I don't know a great deal about the Soviet health care system with regard to geriatrics. I know a bit about western European countries and we are a bit behind most western European countries, most notably England, which has the most developed system for geriatric care. There is one problem with Britain's system for geriatric care and that is in terms of geriatric medicine, it's a bit of a splinter group in terms of being split off from the main body, if you will, of medicine itself, but the system of support and care and the distribution of resources within the health care system in Britain in terms of the needs of the elderly are much more appropriate in my opinion than are the distribution and resources in the United States, and geriatric medicine as an academic and a practiced discipline is far more advanced in Great Britain. In addition, Sweden has a particularly advanced system and most of the western European countries have a slightly higher proportion of elderly people and are a little bit more advanced than we are, although we have made great strides in the last 20 years. We are making pretty fast progress and with the kind of support that we are talking about today, you could see us catching up with other systems very quickly.

Senator Sasser. Why don't we turn now to Mr. Brown, and Mr. Brown, we will be delighted to hear from you.

TESTIMONY OF JAMES BROWN, CHIEF NURSING HOME ADMINISTRATOR, OAKVILLE HEALTH CENTER, MEMPHIS, TN

Mr. Brown. Thank you, Senator. Let me briefly tell you about our two facilities that I happen to be the executive director for. They are county-owned and operated, and we have approximately 890 beds and we generally run 98 to 100 percent occupancy. Our operating budget is approximately $20 million per year. Third-party payment on that $20 million is about 67 percent and that generally is Medicare and mostly Medicaid. The other 6 million comes from the county taxpayers.

Very briefly speaking about catastrophic care, a catastrophy can be defined as a disastrous finish or conclusion, any misfortuante, mishap or failure. The above definition is especially appropriate when thought of in terms of the elderly who have faced potential bankruptcies and loss of financial independence as a result of a lengthy, debilitating illness. During the past decade legislators, Federal and State agencies, health care professionals have struggled with the issue of health care costs, and while Medicare and Medicaid were originally thought to be panaceas to reduce the out-of-pocket costs for the aged and poor, instead the opposite has proven to be the case.

Escalating health care costs have resulted in older Americans actually paying more of their income for doctors, hospitals, drugs and long-term care than they did before Medicare was enacted in 1965. Some of the reasons for these spiraling health care costs can be attributed to the implementation in 1983 of the prospective payment system and DRG's for hospitals which has resulted in a reduction in the number of days a patient remains in the hospital and secondly, to the decreasing number of physicians willing to accept Medicare assignments. Because the hospitals are discharging patients earlier, many patients that previously would have returned home to be cared for by families are unable to do so and often must be admitted to the intermediate care facility or the skilled nursing facility.

Once admitted to the facilities, reality must be faced that Medicare often does not cover all of the services required. Those services not covered include eyeglasses, dentures, dental care, and home health care services except under increasingly limited circumstances.

Health care costs have had a disproportionate impact on older Americans. From 1950 to the present, statistics indicate that the Nation's elderly have continued to be sick three times as often and three times as long as their under 65-year counterparts and some provision must be made for the care of those persons. In many instances the aged person does not have a family to take care of them and for those persons with families, the families may be unable or unwilling to provide the care needed. Not only are the elderly often three times sicker than their counter-parts but in addition, they pay nearly three times as much as the younger adult for health care, even though many of them are on fixed incomes.

In 1966 the average aged American paid an average of $445 per capita for health costs while in 1986 per capita expenditures averaged $4,601. The largest percentage of the elderly health care dollar goes for the payment of hospital care, some $59.3 billion, while nursing homes received less than half of that amount, or $27.5 billion in 1986. What many persons fail to realize is that nursing home care is one of the fastest growing segments of health care expenditures, and the public hue and cry for improvements for service has resulted in even greater cost expenditures. We should all recognize the fact that raising the standards without a corresponding increase in resources for available funds may actually result in a deterioration of the kinds and amount of care that are available. Public funds dispersed at a fixed rate may not be sufficient to reimburse all service components necessary for compliance standards.

Disadvantaged groups are particularly vulnerable to the gaps which may occur when resources are not matched to requirements. The sad fact is that Medicare and most other private insurance provided little if any of the costs of nursing home care. Even if it is a matter of life and death, Americans both young and old or their families are left to fend for themselves in dealing with these increasing health care costs. The end result for most institutions, the question must be answered where do we go from here?

As Dr. Applegate alluded to, by the year 2020, the over-65 population will probably be in approximately 35 percent or three times today's rates. Of that 35 percent, 10 percent of them will be 85 years or older. The baby boomers that we often speak about will be coming into the Medicare/Medicaid picture about that time. The average length of stay in a Tennessee nursing home is 354 days.

Medicare now pays 100 days of skilled nursing care, nothing for intermediate care, so that leaves a big gap in the coverage. Less than 3 percent, actually 2.6 percent, of patients in Tennessee nursing homes are Medicare patients. Less than 1 percent of Tennessee nursing homes' patients have their care paid for by private insurance. There are a number of private insurance companies who are now getting into the long-term care business, some good, some bad.

Our professional organization, THCA, or Tennessee Health Care Association, has endorsed a policy that they have looked at very deeply and investigated and found them to be reliable. That same company is endorsed by 15 other State associations. The average age of policy buyers for this type of long-term health insurance is 72 years of age. The problem I have with the private, long-term care health insurance and particularly in my facilities and in Shelby County, are the numbers of people who will not be able to afford the premiums, whatever they are. Thank you.

Senator SASSER. Thank you very much, Mr. Brown. Again, let me say that we appreciate your testimony and also appreciate your graciousness in letting us use these facilities today.

I'm going to have to close the hearing because we are gong to have to rush out the door, but I do thank all the witnesses for their testimony here today. I think these hearings have been very worthwhile from the point of view of developing information that we will be able to use in formulating legislation, legislation that we can use on the Senate floor. These hearings also serve an educational process in educating the public at large as to the problems facing the elderly in this area with regard to meeting their health care needs.

Thank you all for your interest and for attending. The Subcommittee is now recessed.

[Whereupon the Subcommittee was recessed to reconvene at the call of the Chair.]

RESOLVING CATASTROPHIC HEALTH PROBLEMS IN THE MEDICARE PROGRAM

SATURDAY, AUGUST 29, 1987

U.S. SENATE,
SUBCOMMITTEE ON GOVERNMENT EFFICIENCY,
FEDERALISM AND THE DISTRICT OF COLUMBIA,
COMMITTEE ON GOVERNMENTAL AFFAIRS,
Chattanooga, TN.

The hearing convened, pursuant to notice at 9:55 a.m., at the Tennessee State Office Building, McCallie Avenue, Chattanooga, Tennessee, Hon. James R. Sasser, Chairman of the Subcommittee, presiding.

Present: Senator Sasser.

Staff present: Dr. John Callahan, Staff Director, John Wagster, Legislative Assistant, and Beth Jones, Special Assistant.

OPENING STATEMENT OF SENATOR JASSER

Senator SASSER. The Subcommittee of Government Efficiency of the Governmental Affairs Committee of the United States Senate will come to order.

I want to say good morning to all of you out here in the audience. I want to thank you for coming here today, those of you who are going to testify. I especially want to thank those who may have come a long distance today.

Now, these hearings that we're having today will focus on the tremendous burden that our senior citizens face in trying to pay their catastrophic health bills.

As the American population grows older, and it is growing older every year, Social Security and Medicare are having a greater and greater impact on the Federal budget.

Today Social Security and Medicare account for about three hundred billion dollars in Federal spending. And that's nearly one-third of the entire Federal budget.

But the flip side of that is that we collect enough taxes every year by way of the payroll tax on Social Security and certain Medicare taxes to defray the cost of Social Security and the lion's share of the cost of Medicare. So the programs are presently solvent and supporting themselves.

Now, these are very extensive expenditures. But they've only helped to make old age livable, according to some experts. They've not solved what the noted geriatrician and Pulitzer prize winner Dr. Robert Butler describes as, and I quote him, "the tragedy of old age in America."

The tragedy, of course, is that most of our older citizens live in constant fear of financial ruin from a catastrophic or long term illness. And I'm sorry to say to you today that their fears are well-founded. The threat of financial ruin from catastrophic illnesses grow worse as our population ages.

Over the past two decades, the number of American citizens age 65 and older has grown twice as fast as the rest of our population.

Just let me demonstrate to you with this chart.[1] In 1900, about 4 percent of our population was age 65 or older. By 1980, that had grown to 12 percent of the population being 65 years of age or older, a 300 percent increase in the percent of our population over the age of 65.

In the year 2000, it will grow to 13 percent. And by the year 2050, almost one out of every four Americans is going to be 65 years of age or older.

Now another example of the aging of the American population is the number of our citizens who will be 85 years of age or older.

Many of our experts classify that population as the very old. And there's going to be an 800 percent increase by the year 2050 in those who are 85 years of age or older.

For example, we had, in 1980 2.2 million people who were 85 years of age or older. That's about half the population of the state of Tennessee.

But by 2050 that's going to increase to 16 million people; almost an 800 percent increase in those who are 85 and older.

We should thank the good Lord and thank medical science that so many of us can now live to an advanced age.

But this graying of America promises to point out and magnify the inadequacies in our present health care system. The elderly are by far the greatest user of health services.

According to the latest statistics, persons aged 65 and older are hospitalized twice as often as younger people. And when they get in the hospital they stay there twice as long. They also use twice as many prescription drugs.

So it should come as no surprise also that as we age, the likelihood of being stricken by a so-called catastrophic illness that requires long term care increases dramatically. The increase is the most dramatic among the fastest growing segment of our older population, those 85 and older.

The elderly, however, currently have almost no options available to them to help pay for expensive long term care. And most of them now very quickly exhaust their own assets if they're forced to pay for nursing home care. And that's no wonder. Because the average cost of a nursing home across the country now runs at $22,000 a year.

The Department of Health and Human Services reports that as many as one-half million elderly people a year, 500,000 a year, will exhaust all their assets, spend all of their personal money, sell all of their possessions to spend down to the Medicaid limit where they can access Medicaid for poor people so they can stay in nursing homes.

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[1] See p. 3.

Now, it's starkly evident that the existing program is falling very short of addressing the problems that they were meant to address.

Ninety-four cents out of every dollar that Medicare spends goes to pay for hospital cost and the fees of various doctors. Only one cent out of every Medicare dollar goes to help the elderly pay the cost of nursing home care.

Yet we find that a relatively large share of our older citizens out-of-pocket health expenses, which they pay for themselves, they pay about 42 percent of the health care costs—a large percentage of that goes to cover nursing home cost.

The painful truth is that there are very large gaps in Medicare coverage; gaps which the elderly now have to fill with money out of their own pockets.

Despite the efforts of the Federal Government over the past 20 years, the direct out-of-pocket health cost for the elderly averaged about fifteen percent of their income in 1984. That's precisely the amount of their income that they were spending to cover health care cost before we passed Medicare over twenty years ago.

So partly out of frustration and partly out of fear, our senior citizens are purchasing supplemental health insurance. These are commonly referred to as medigap policies.

Now, most of the elderly believe that their supplemental medigap policies will pick up everything that Medicare doesn't pay. But the facts are that they will not.

Most of these policies cover none of the cost of nursing home care and they do not fill the largest gaps left by Medicare.

The great tragedy is that our older citizens many times find themselves victims of what I can only call unscrupulous medigap insurance salesmen who will play on the older citizen's fear of catastrophic illness to convince them that they need to buy one or sometimes several unneeded insurance policies.

I have heard of cases of individuals paying literally over thousands of dollars a month for multiple medigap policies that duplicated coverage they already had but did not offer them the coverage they needed.

Now, both the Administration and Congress have come to grips with the fact that the private insurance alone can't handle the health care needs of the elderly. We are seeing action now to offer protection to senior citizens by the fact that earlier this year the Secretary of the Department of Health and Human Services issued a report on catastrophic illness expenses. This report served as a blueprint for legislation which passed the House earlier this summer.

When the Senate goes back into session in about a week and a half, we're going to quickly take up a bill similar to the House-passed catastrophic health care bill. And I look forward to the comments some of the witnesses will have on this legislation which will be pending.

Now, I'm pleased that we've addressed the problem of catastrophic illness coverage in the House and will have a Senate bill on it. But frankly, this legislation just simply doesn't go far enough. It doesn't deal with the problem of long term health care costs.

I've introduced legislation in the Senate and Congressman Claude Pepper has introduced similar legislation in the House of Representatives that will address the problem of long term care to cover many of the problems that the legislation presently pending does not.

The legislation we've offered would cover long term and extended hospital stays as major health care expenses for the elderly, cover things such as routine doctors visits, dental bills, eye examinations and eye glasses, and also cover the need for hearing examinations and hearing aids. In the restructuring that we're going through now to try to address the needs of our elderly citizens and the need for long term care, we should include the study of geriatrics; and that's the medicine for the special needs of the aged. We must recognize that our elderly suffer from a host of chronic and multi-dimensional illnesses that are difficult to treat. We should recognize the need for specialists to deal with the illnesses of the elderly. You know, we have pediatricians who deal with illnesses of children. But we need to have more geriatricians who will deal with the problems of the illnesses of our elderly population. Now presently there is a lack of geriatric training in the United States. About 75 percent of the medical schools in this country now offer courses in geriatric medicine. But the problem is that only 4 percent of medical students take these courses in geriatric medicine.

The one reason for the scarcity of doctors who specialize in geriatric medicine is that treating the elderly population is simply not very glamorous. Doctors like to treat people that get well in a hurry because one of the rewards of being in the practice of medicine is seeing your patients progress and get well and strong almost before your very eyes. But that's rarely the case with chronic illnesses that an older person has. They tend to recover very, very slowly. And sometimes doctors just don't see the results that they like. So as a result, most doctors tend to lose interest in the study of geriatrics, and health care for the elderly suffers to some extent.

I think if health care for the elderly is going to improve, we must train physicians to deal with their special needs.

So I've introduced legislation which will establish national centers of excellence for geriatric training across this country. These centers will help train medical specialists dedicated to improving the quality of care that our senior citizens receive.

This issue may be debated during the Catastrophic Health Care Bill in the Senate. And I intend to do my best to see that we establish these centers of excellence to encourage young doctors to go into the field of treating our older citizens, to specialize in geriatric medicine.

Well, I've talked long enough. And we've come now to hear from some of our interested citizens and witnesses.

We'll begin today with two witnesses; first, Mrs. Nancy Broyles. Mrs. Broyles, would you come forward, please? And also Mrs. Grace Maxine Henley. Would you come forward, Mrs. Henley? Just come forward, if you will, ladies, and take a seat.

Let me begin by saying that Mrs. Broyles is the wife of an Alzheimer's patient who started showing signs of this dreaded disease at the age of 52.

She cared for her husband at home for 6 years until she was no longer able to do so. She sold many of the family's possessions, including their business, to help pay for her husband's nursing home expenses. And she's now come out of retirement to work to help support him.

Mrs. Grace Henley is the wife of a former railroad worker who's been ill and unable to work for the last 20 years. She cared for him at home as long as she was physically able, and finally enrolled him in a nursing home a little over a year ago. She and her husband are forced to make do off of Social Security and a small pension.

Mrs. Broyles, we'll begin with you. I want to thank you for coming here today and sharing with us your experiences, because I feel they'll be very helpful to us in trying to arrive at legislation which will make sure that what's befallen you doesn't befall others.

So why don't you pull that microphone just a little closer and tell us your story.

TESTIMONY OF NANCY BROYLES

Mrs. **Broyles**. Senator Sasser, distinguished visitors, ladies and gentlemen. Thank you for the opportunity of appearing here today.

I hope this hearing is an indication that our elected representatives are sincerely working on what I consider to be the primary question on the minds of our Nation's elderly.

That question is, if I need Medicare, will it be there? In my husband's case, it was not.

During the good times, my husband and I owned and operated a family supermarket. We carried full health and life insurance coverage for ourselves and our family. We put aside what we could for our future. We worked hard and invested our time and money in providing for a comfortable retirement. In short, we did everything we knew how to do to prepare for our future.

At the age of 52, my husband became ill and was diagnosed with Alzheimer's disease. His disease was unknown to us. We had never even heard the word Alzheimer's. We had health coverage but not for this catastrophic illness.

His disease has now progressed to the present point where he is unaware of his surroundings. He is incontinent and cannot perform even the simplest task necessary for daily living. He is unable to speak and doesn't respond to anyone.

I am now paying over $1,800 a month for his care in a nursing home because I am physically incapable of lifting a man his size. Admitting him to a nursing home was the most traumatic event in my life.

To be very realistic, knowing that I would be paying this large sum every month for a very long time probably, added to the trauma.

I was becoming personally acquainted with the catastrophic illness. As I testified earlier before Representative Pepper, we have lost our business and much of that which was put aside for our retirement to pay for his care.

When he became disabled, our private insurance became secondary. It would pay only that which Medicare did not pay.

Well, Medicare doesn't pay for anything connected with Alzheimer's disease. Therefore, this insurance we've been paying a monthly premium of $148 a month did not pay.

Working Americans see Medicare as protection for their older years. We expect, if something happens to us, that this large, expensive system will be there to do the job it was designed to do, which is, provide protection against the threat of high cost medical treatment at a time when private medical insurance is unavailable or unaffordable.

A great number of us have spent large sums to purchase medigap policies to supplement our Medicare protection. It is obvious when Medicare doesn't pay, our medigap policies are worthless.

In that case, our piece of mind, which we have paid for, is a sham. And in my family's case, it's been a crisis in our lives.

In short, Medicare sets the pace. And the system really needs some work.

Elderly Americans are not faced with the same type of medical problems as their younger counterparts. While Medicare provides some protection, in many situations that is not good enough.

For seniors faced with the prospect of long hospital stays and extended nursing home care, there is no insurance option now available.

Medicare must be changed to provide the type of coverage which seniors are presently unable to obtain and which provides the most potential for any medical crisis they may experience.

As a side issue, it is my opinion that until Medicare is amended to provide long term hospital benefits, extended nursing home care and other geriatric type of medical benefits, the level of medical care presently available to our elderly will not improve.

I feel that physicians, for the most part, will never be interested in practicing geriatric medicine until a fund is available to pay for their services.

I have perceived a disinterested attitude. And I question whether it's because they feel nothing can be done for an Alzheimer patient or is it because they know that I'm their only source of payment.

I had a physician tell me he would like another brain scan, that it would be beneficial in my husband's case since several years had passed since one was done. But he would not hospitalize him and run these tests because of the high cost that I would have to pay. How can I possibly feel that everything possible is being done for my husband?

When you have a diagnosis of Alzheimer's disease, it is indeed a kiss of death.

Senator Sasser, if you and your colleagues would go look at my husband and others like him, I feel that you would think their condition warrants consideration from the Medicare program.

The prison system provides full medical services to those incarcerated. Those who choose not to work are treated by the very best physicians. But senior Americans and victims of Alzheimer's disease are told to leave the hospital or that "that disease" is not covered.

Is this the American way?

I have gone to work to try to sustain myself. And at my age, entering the work force is not easy. There is no way I can start at the bottom and earn the kind of money it takes to meet the monthly bills incurred with a catastrophic illness.

My 4-year-old granddaughter has Downs syndrome. And if she lives to middle age, will have to depend upon Medicare. Research tells us she will develop Alzheimer type symptoms. And I will be leaving nothing to care for her. Who will?

In closing, I must say that it is painful and embarrassing to publicly discuss these personal, financial and emotional issues.

However, if this proceeding can cause Medicare to be amended in the ways I've discussed and bring peace of mind to the elderly and to the victims of a catastrophic illness, then I feel duty bound to speak out.

Thank you.

Senator SASSER. Thank you very much, Mrs. Broyles. I know that it's not easy to bare a lot of your personal life and personal problems here publicly before others. But you perform a great service in doing that. Because in so doing, I think you educate a large portion of people who simply are not aware of the problems that we have with the Medicare system and the gaps in coverage that are in it.

To close these gaps is not going to be cheap. It's going to cost some money. And we're going to have to have public support from the population of the public at large before we can go forward and do that.

Let me ask you just a few questions. Now, your husband was 52 years of age, is that correct, when he started developing these symptoms?

Mrs. BROYLES. That's correct.

Senator SASSER. And you cared for him at home for how long?

Mrs. BROYLES. Almost 6 years.

Senator SASSER. And then it became impossible for you to do so because you couldn't lift him?

Mrs. BROYLES. That's right.

Senator SASSER. Did you have any supplemental medigap coverage when your husband became ill, any supplemental health insurance over and above Medicare?

Mrs. BROYLES. I had health insurance. But when he became disabled and was eligible for Medicare, it automatically became a Medicare supplement.

Senator SASSER. Did that policy give you any help with regard to——

Mrs. BROYLES. None.

Senator SASSER [continuing]. Nursing home cost or any other long term health care needs?

Mrs. BROYLES. No, sir, no help whatsoever. And I subsequently dropped it.

Senator SASSER. Would you have any advice to others as to what they might do if they were going to be faced with a similar situation? Did it do any good, in your view, to carry these medigap policies, these health insurance policies when you're confronted with long term health care problems?

Mrs. **Broyles**. In my opinion, the medigap policies are of no value. They only pay after Medicare pays.

And the structuring of Medicare as it is—I can speak about Alzheimer's disease. That's the one that I am familiar with. Anything as long as that word's on there, Medicare doesn't have anything to do with it. So any supplementary policy doesn't either.

Senator **Sasser**. You've been living with this problem for how many years now?

Mrs. **Broyles**. For almost 9 years.

Senator **Sasser**. You've been, by and large you've had to support your husband's illness out of what you've accumulated in the past years?

Mrs. **Broyles**. That's correct. And anything that I could turn into cash.

Senator **Sasser**. Then you had to sell off your possessions?

Mrs. **Broyles**. Everything. That's correct.

Senator **Sasser**. Well now, what are you going to do for yourself in later years? In other words——

Mrs. **Broyles**. Well, I guess I'll qualify for Medicaid, because my assets will not be $1,500.

Senator **Sasser**. I see. Well, I think that illustrates the tragedy of how one spouse, in order to pay for the illness of another, must simply, over a period of years, sell off everything that the couple has accumulated. And it leaves the remaining spouse, many times, destitute.

Mrs. **Broyles**. That's correct.

Senator **Sasser**. Mrs. Henley, do you have a statement for us this morning?

Mrs. **Henley**. Yes, sir, I do. I may not put in context like Mrs. Broyles, but every case is different.

TESTIMONY OF GRACE MAXINE HENLEY

Mrs. **Henley**. Mr. Sasser and friends: I am Mrs. Grace M. Henley. My husband is Grover C. Henley, and is a patient at Heritage of Collegedale Nursing Home, and has been since February of 1986.

He retired from the railroad in 1979, but Parkinson's disease had already set in. I kept him at home trying to take care of him by myself when he had a near fatal car accident in July of 1980. And it has been downhill ever since the accident. There's brain damage and seizures from brain damage.

Our monthly income together is $1,866.17, of which I must pay $1,364 for a 31-day month care. I have also to pay for his medicine, he is a diabetic, and medication for seizures, which is Dilantin. My payout for our drugs vary. I am also a diabetic. I have high blood pressure and gout.

I get our medicine at the cheapest place I can find. My payout for insurance is $1,464 per year. And I must say that the insurance is a part that we had while he worked at the railroad, which is Travelers. And after he retired, it did not have the coverage, we did not have the coverage that we had while he was working.

I have sold clothes, luggage, jewelry, small appliances in order to make ends meet. I also have cashed out a life insurance policy on myself to help to, for my food and personal things that I must have.

Before I put Mr. Henley in the home, which was the hardest thing I ever did, I paid Mrs. Bonnie Rich $100 to help me two-and-one-half days a week. But my doctor said I'd gone as far as I could go without a nervous breakdown.

Yes indeed, I am for paying more on our Medicare coverage, which—I mean on our Medicare premiums for our nursing homes. And I'm sure everyone over 65 that has a loved one will agree with me. Because after the first of the year, our rates will go up $2 a day. And I just don't see how I can pay more.

Senator **SASSER**. Thank you very much, Mrs. Henley.

Now, I'd like to just go back to this question. We have proposed legislation that would include payment under Medicare for long term health care needs. That would include, in your situation, payment for nursing homes, would include drug expenses, and as I said earlier, would include even dental expenses, eye glasses, and hearing aids.

I'll ask you and Mrs. Broyles both, would you be willing to pay 15 percent more on your Medicaid premium per year to access that type of coverage?

Mrs. **HENLEY**. I would.

Senator **SASSER**. How about you?

Mrs. **BROYLES**. I'm definitely for it.

Senator **SASSER**. And how would you feel about it being mandatory, in the sense we would compel everybody to pay for coverage? Because if you didn't, what we'd do, we'd find that all the sick people would want to get under the coverage but, many of the well people—nobody thinks they're ever going to get sick and nobody thinks they're ever going to get old until they get there—many of the well people wouldn't opt to get under the coverage unless we made it compulsory.

How do you feel about it being made compulsory; the Government saying, you must pay into the Medicare system an additional 15 percent if you're able to, just like you have to pay into Social Security? How do you feel about that? Does that offend you, or would you be willing to do it?

Mrs. **HENLEY**. Well, for myself, I don't feel like I have any other choice. I mean, you know. I just don't have any other choice. Because I'm at my wits end, you know.

Senator **SASSER**. How would you have felt about that 20 years ago, Mrs. Henley?

Mrs. **HENLEY**. I would have felt the same, because after all, I had a mother and I knew of other people that was coming up to the age of 65. I was a young person then and I worked and I paid my Social Security.

And I think if Medicare had of been in effect then, I believe I would have felt the same way. Because after all, everybody has to be taken care of. And there comes a time when you can't. But that person still has to have care.

When you can't take care of them yourself—I did fairly well with him for 5 years. But when you can't take care of that person yourself and you have to put them in a home, you don't have no other choice.

Now, that's my feeling.

Senator **Sasser**. How would you feel about it being compulsory, Mrs. Broyles? Would that bother you?

Mrs. **Broyles**: I think you would be doing people a favor. And I think it should be. Fifteen percent is nothing.

Senator **Sasser**. Well, we calculated that when you add in the amount that most of our older citizens now pay for medigap insurance policies that really don't help them when they get into serious trouble with the long term illness, as both of you have found out, that actually our older citizens might be paying less on a yearly basis for this coverage than they might be with the old Medicare and medigap policies, substantially less.

Well——

Mrs. **Henley**. Let me say one thing.

Senator **Sasser**. Yes, ma'am.

Mrs. **Henley**. I did not take out what you call the medigap. I stuck with my Travelers insurance that we had when Mr. Henley worked for the railroad. Because I felt like by doing that—I had so many friends that had gone ahead and took out extra insurance and then it didn't live up to its promise. So I kept my insurance that I had when Mr. Henley worked for the railroad.

Senator **Sasser**. Well, I want to thank both of you ladies for coming here today and sharing with us your experiences. And hopefully we'll get things arranged some time in the future where others won't have to repeat the tragedy that you've gone through. Thank you very much.

Mrs. **Henley**. Thank you.

Mrs. **Broyles**. Thank you.

Senator **Sasser**. Our next group of witnesses will be a panel consisting of Ms. Lynn Deckman, an attorney for Tennessee Legal Services; Mr. Rufus Williamson, Government Affairs Department of Blue Cross and Blue Shield; and Mr. Farrell Cooper from the Erlanger Medical Center.

Let me just say a word about these witnesses. Ms. Lynn Deckman is a senior citizen attorney for Legal Services here in Chattanooga. She specializes in areas where senior citizens are targets of abuse. This ranges from Social Security benefits problems to Medicare-Medicaid appeals to insurance problems. And her services are available to individuals over the age of 60.

Mr. Rufus Williamson is vice president of Governmental Affairs for Blue Cross-Blue Shield. He is very knowledgeable about Medicare supplemental insurance policies, and he is going to share with us some of his knowledge and expertise this morning.

Our final witness will be Mr. Farrell Cooper. Mr. Cooper is the Director of the Social Services Department at Erlanger Medical Center here in Chattanooga. One of Mr. Cooper's primary duties is to develop post-discharge care for elderly patients.

Because of his position at Erlanger, Mr. Cooper has a unique perspective and vantage point on which to judge and assess the health care problems of the elderly.

I want to welcome all three of our panelists here this morning and express my appreciation to you for taking your time on a beautiful Saturday morning to come here and be with us.

We'll start first with you, Ms. Deckman, and then move on to Mr. Williamson and then Mr. Cooper.

Do you want to grab the mike and pull it just a little closer, please?

LYNN DECKMAN, ATTORNEY, LEGAL SERVICES, CHATTANOOGA, TN

Ms. DECKMAN. As a senior citizen attorney for this area, one thing that came to mind when I was thinking about this last night was that over the 3 years, that I have seen poor woman after poor woman after poor woman come into my office. I don't know why they're poor, I imagine they started out poor possibly.

But in talking with them, and I always spend time with my clients, I find that I hear stories of husbands who have been ill, and this is now, their condition has left them with very little to live on. They have very little assets. And that's the way it is.

Of course, I do appeals in all the benefits area. And I normally find out specific instances of problems when I do these appeals.

Right now I'm doing one for an elderly lady who has nothing. Her husband was put in a nursing home after a stroke. For 60 days Medicare paid for his care. After 60 days, she was informed his condition was getting worse, we're taking him off Medicare. She then was required to sign a private pay contract. And since the nursing home didn't have a Medicaid bed, they were eligible for Medicaid, they had to wait for the Medicaid bed in Hamilton County Nursing Home to become available. Thirty days later one became available and he was transferred to Hamilton County Nursing Home where he eventually, a month later, had another stroke and died.

I'm doing the appeal because she has now been informed she owes $1,400 on, and with this of course there's one-third attorney fees which will be added to the $1,400 and court fees, so it'll be over $2,000.

The only assets she has, of course, is her home. Of course I would file a claim for exemption because it's under $4,000 for personal property and bank accounts, but she really has nothing except her home. So probably what will happen will be a lien put on her house, the only asset she has.

What is so sad about this is that his condition worsened as she put him in the nursing home. The doctor requested daily physical therapy. The admitting diagnosis and the diagnosis—the admitting diagnosis—let's say he could feed himself. Everything had worsened.

So I have appealed the process. It's gone on for, I guess about 6 months. Fortunately the attorneys on the other side are holding up until we get some decision. But this is the kind of thing that happens. And I only see the tip of the iceberg.

I know there's a lot of people out there that don't know that I'm available, even though I go talk to group after group after group, trying to tell them about my service. I went to at least 40 different organizations or senior groups last year.

The next type of situation that we get is something that I think happens a lot, spousal impoverishment. When one spouse, usually the husband, goes to the nursing home, the wife at home is left to live on a very little bit of income, two-thirds of the husband's amount. And this is when the person is ineligible for Medicaid. She must live on a very little income to keep the home going, keep the payments for medical bills.

I have noticed in California that they have a new Medicaid law. You might have to correct me on some of this, but I think they have community property out there.

The situation is such that when they go into the nursing home under Medicaid, half the resources are attributed to the wife and half go to the husband. The same income is split in half.

Tennessee probably needs to adopt this type of legislature to try to keep—usually it's the woman who's usually left at home for 20 more years or so, from not being so poor.

The third problem I see a lot of is of course the complexity of the Medicaid system. No one really understands it from the top down. I mean it is so complex; how to get in, how to be eligible, how to do this, how to protect your resources that we have situations happening because of the lack of the public being educated. They're afraid. They're afraid of losing their homes to Medicaid. I hear this over and over again.

I had a situation 2 weeks ago where a husband, he's the second husband, contacted me, his wife has Alzheimer's. He signed and she signed the deed to their home over to their children. They did this in fear of the eventual problem that Medicaid would take their home away from them.

Of course if he had stayed there, if someone had told him you don't have to do that, that its not considered an asset if one spouse remains in the home, they would not have done that.

So now what probably will happen, the minute she gets in the nursing home, the children will probably boot the stepdaddy out of the house.

At least I've gotten in touch with him and we might be able to take some steps. But if I hadn't, if he didn't know me and I couldn't have stopped something like this from happening, he would probably be another little homeless elderly gentleman.

So those are three areas that I just pinpointed out about spouse impoverishment that I see a lot of.

Senator **SASSER**. Well, are you familiar with the expansion of Medicare as we propose to do under the Medicare C legislation?

Ms. **DECKMAN**. Yes.

Senator **SASSER**. Well, do you think that will alleviate some of the problems we're talking about here today, the problems of the number of clients that you see?

Ms. **DECKMAN**. I think it is important that if you do a C type insurance that there must be some provision for the custodial care. There are three levels of care; the custodian, intermedial, and the skill.

This seems to be a way, and I'm not being bad when I say this, but for the bureaucracy to knock people out of the nursing homes and for the care. If we can make it very clear in the bill that——

Senator **SASSER**. That it precludes custodial care?

Ms. **DECKMAN**. Includes custodial care under certain circumstances. I'm afraid what will happen is they'll say "a skilled nursing home" and make the criteria so difficult for someone, you know, so difficult for someone to be under that criteria.

And that's one thing that I would hope that would be in the bill; to include custodial care.

Senator SASSER. Do you run into the problem of unscrupulous medigap insurance salesmen here in Chattanooga? Do you have some problems with that as in other areas of the state? I'm not talking about Blue Cross-Blue Shield, Mr. Williamson.

Ms. DECKMAN. It's the door-to-door type problem. I had a lady come into me, bless her heart, she had 10 of them.

Senator SASSER. Ten medigap policies?

Ms. DECKMAN. Yes.

Senator SASSER. Why did she buy all those policies?

Ms. DECKMAN. Why? Well, I'm not really sure. But yesterday I was up talking to a group at Alexian Village, which is a very wealthy group. I told them about this, and I asked them, "Why do you think she did this?" And they'd said, "Fear." Which was very interesting. They knew why she bought it. She may not have been able to verbalize it to me. But it's the fear. I notice you had said that also.

Senator SASSER. Well, interestingly enough, we were in Memphis holding hearings on this same problem earlier this week, and there's a survey that's come out by the Tennessee Health Care Association. According to this survey it said that Tennesseans dread the idea of going to nursing homes and they fear the problem of catastrophic illness and being unable to pay for it.

I'm now looking at this scientific survey. Eighty-eight percent of those surveyed said insurance companies should offer policies covering long term health care cost.

I think this is a reflection of their fear of not being able to deal with the long term health care cost on their own.

Of course they don't know what those premiums would be if the companies did offer long term health care coverage. Maybe Mr. Williamson could give us some idea about that later.

Do you feel that your clients are well-informed about the terms of those medigap policies that they purchase, or not?

Ms. DECKMAN. Well, Legal Services—and I believe you've seen this book, Medicare Supplemental Insurance. When I go out to the groups, this is a book about supplement Medicare. I talk to them and I give out the books. But of course I can't get enough books to go around to everyone.

But I do explain to them how it works. And they're real surprised. They are so surprised and they don't understand the approved part. They see the things on television that say that it pays everything that Medicare doesn't pay for. They don't understand that it pays just the gap of what Medicare approves. And that has to be explained to them.

So that is one of the things. They do not, on the whole, understand how it works.

Senator SASSER. In other words, if Medicare doesn't pay a portion of the expense then the medigap policy doesn't pay it?

Ms. DECKMAN. No. They don't understand that if Medicare gives an operation, let's say for $1,000, the operation costs $1,000, and Medicare only approves $500. They did not realize this other $500 would not be covered by the supplement. Only 20 percent is covered by the supplemental. They don't understand that. They think the whole $1,000—the $500 would be covered by the Medicare supplement. So that's a shock to them. They just don't believe that.

Senator **Sasser**. To your knowledge and based on your practice here, are there unscrupulous medigap salesmen operating in the Chattanooga area? They've isolated a number of them in Nashville. There have been medigap door-to-door salesmen misrepresenting the terms of the policy, staying in the elderly person's home sometimes, as testified to yesterday, as long as 5 hours until an elderly person would agree to purchase the medigap policy.

Are you running into anything like that here in your practice?

Ms. **Deckman**. I have not heard of that, but I would not be surprised.

Just like the lady who had the 10 policies, I think what they did, they'd keep coming back and add on at different times. It was a more gradual thing with her, him talking her into it.

Senator **Sasser**. Thank you, Ms. Deckman, for your testimony.

We'll now turn to Mr. Williamson. And if you have a prepared statement, Mr. Williamson, we'll be glad to receive it.

TESTIMONY OF RUFUS WILLIAMSON, VICE PRESIDENT, GOVERNMENTAL AFFAIRS, BLUE CROSS/BLUE SHIELD

Mr. **Williamson**. Thank you, Senator Sasser. I'm Rufus Williamson, vice president of Blue Cross/Blue Shield of Tennessee. And I will try to address briefly the item you mentioned about long term care cost during my remarks.

Although more than two-thirds of Tennesseans with Medicare, including subscribers at Blue Cross of Tennessee, have protection against catastrophic loss from hospital and medical expenses, many others do not have protection and consider themselves in financial jeopardy should they have a major illness or injury.

For those without insurance protection or Medicaid coverage there is a real need for assistance in preventing the loss of financial security due to unexpected medical expenses.

As to the need for catastrophic coverage, there's no doubt that the Medicare program, as it's currently configured, does not provide comprehensive protection against high side costs resulting from major, acute and some chronic illnesses.

Even though the assignment rate, and this was addressed by Ms. Deckman, the assignment rate on Medicare Part B which determines the relationship between the amount Medicare pays, the approved amount, and the charges by physicians is going up in Tennessee. It's now 70 percent. Which basically means that 70 percent of the claims coming through on Medicare for physician cost, there is no difference between the approved amount and the amount that's handled by Medicare except the 20 percent co-insurance.

The problem in the past has been that there has been a majority of bills with potential differences above the approved amount that the patient would have to pay. That's improving. But still there's 30 percent of the bills coming in that are probably not completely covered by Medicare.

On the hospital insurance, or Part A side of Medicare, the multiple hospital deductibles are $520 for confinement at least 60 days apart, and the limit of 150 days in the hospital and 100 skilled nursing home days have placed some beneficiaries at risk financially. Therefore, the need is clear for more comprehensive health care protection for the elderly.

Now, on the subject of medigap insurance. The private medigap insurance plans offered by Blue Cross and others are being used by Medicare beneficiaries to protect against excessive out-of-pocket costs for acute hospital and physician care.

According to the Congressional Budget Office, about 72 percent of elderly supplement Medicare with private coverage. About half of the supplemental coverage is provided on a group basis through the retirees former employer, and about half is purchased individually. Most medigap policies do not provide coverage for long term care.

There's a wide variety on the market of both group and individual supplemental policies with substantial variations in cost.

The supplemental policies offered by Blue Cross and Blue Shield of Tennessee are currently paying out more than 95 percent of the amount paid by the subscribers for the coverage. That's excluding overhead.

Senator SASSER. Would you repeat that, Mr. Williamson?

Mr. WILLIAMSON. Yes, sir. Supplemental policies offered by Blue Cross and Blue Shield of Tennessee are currently paying out more than 95 percent of the amount paid by subscribers for the coverage. And that excludes overhead.

So in effect, what it amounts to right now is——

Senator SASSER. You're losing money.

Mr. WILLIAMSON. We're losing money. That's right.

While some policies provide greater or lesser coverage than others, the protection against major financial loss is generally included in the policies offered by well known companies.

And I think you've referred earlier to some of the companies that I would call fly-by-night companies that do offer a door-to-door marketing that is substandard coverage.

But I'd say there's a good bit of safety in dealing with well known companies such as Prudential and Blue Cross. Prudential's the underwriter for AARP coverage.

To protect the elderly against low value insurance, 46 States including Tennessee have adopted requirements that meet or exceed the Baucus Amendment specifications for certified medigap policies.

These policies provide at least a minimum set of benefits and pay out more than 60 percent of the income for benefits.

According to the General Accounting Office, GAO, the Blue Cross plans in the various states traditionally average above a 90 percent pay out compared to the much lower pay out for commercial insurance companies.

Let's talk a little bit about some specific needs.

The problem that needs a conclusion is therefore not primarily for those with insurance coverage or those with Medicaid coverage but the 18 to 20 percent with no coverage at all except Medicare.

The problem is primarily one of affordability for those with no coverage. For long term care, the problem is both affordability and availability.

And I might mention here that what I mean by availability is there are not many companies that are currently writing long term care insurance. The reason for this basically is that people will not pay the premiums for them.

If you wait until you need the coverage, if you're 65 years old and you want to buy long term care coverage, the premiums are going to be extremely high. And I've not seen any actuarial studies because there aren't enough companies, frankly, that offer the coverage. But I would say the premiums would be close to $100 a month or more, if you wait until you're age 65.

The solution of course is to start buying the coverage when you're 35, which the premiums would be very, very low at that time, and then have the actuarial value increase over time to the point where when you need the confinement and you need the pay off then there'll be money there to pay the claims.

So that's the real problem with long term care is that people simply will not buy long term coverage when they're 35 years old.

And I think that's an education problem. I think that's all that is. People need to be educated to the point that they've got to plan ahead for these types of expenses. I don't think we can totally rely on the Government to take care of these.

Senator SASSER. Mr. Williamson, I don't have, I'm not very optimistic that we can educate a healthy 35-year-old person to believe he or she ought to be purchasing a policy for long term health care. That sort of flies in the face of human nature. But perhaps we could. Please go ahead.

Mr. WILLIAMSON. Well, I think the problem that we also face, as you well know, is that we're now mortgaging future generations, though, the level of benefit they're developing now.

I notice your chart up here says that by the year 2000, 13 percent of the population will be over 65. Actually another factor that's coming into play is that by the year 2012, the babyboomers will have all retired. And the number of people working to support them is only going to be about 2.4 people working to support all of those retirees. So we're going to have to make our problem financing, which is my next subject.

As Congress and the Senate in particular address the issue of affordability, or ability to pay, related to catastrophic costs, I would like to suggest that you consider either (A) An income related premium set to finance the cost of catastrophic benefits added to the tax liability of individuals who must pay, who must file tax returns and pay taxes.

For example, those required to pay taxes of 15 percent to pay one amount, say, $100, and those in the 28 percent bracket, a larger amount, say, $200 or $300.

And then (B), the other option, would be setting the benefit level for out-of-pocket caps based on income.

For example, setting the cap for out-of-pocket $2,000 for most beneficiaries but a higher amount for higher income beneficiaries. The premium charge in this situation would be the same for everyone.

Then on the subject of future cost, again addressing the situation of mortgaging future generations, to reduce escalation of medigap premiums in the future, it is important to limit the escalation of deductibles and out-of-pocket caps. This is a major problem. As you know, as inflation comes along and these deductibles and co-insurance items rise, then that's when people that thought they were okay are in trouble.

Senator SASSER. You're telling us, Mr. Williamson, that we could, at age 65, probably purchase long term health care for $100 a month?

Mr. WILLIAMSON. Something around $100. I don't know the exact amount.

Senator SASSER. What companies sell that coverage?

Mr. WILLIAMSON. I'm only aware of a couple of companies. And I think they're doing it basically on a pilot basis. I think that Prudential currently has a pilot plan somewhere. And there's one other company, a major company, I think it may be Mutual of Omaha, that is working on some kind of a pilot coverage.

Senator SASSER. Have you seen any figures to indicate, any loss experiences or extensive loss experiences on those policies yet?

In other words, have you seen any particulars as to the benefit of their paying out versus premium dollars taken in?

Mr. WILLIAMSON. No. I think they haven't been in effect long enough to have really good actuarial data available yet.

Now, I think there have been some companies that have been writing this type of insurance for long periods of time, but they are very careful and tightly underwritten. They're basically for healthy people and they're written at a younger age. And I think they are not broad enough to really offer that much actuarial data yet.

Senator SASSER. All right, sir. Mr. Cooper?

TESTIMONY OF FARRELL COOPER, DIRECTOR, SOCIAL SERVICES DEPARTMENT, ERLANGER MEDICAL CENTER, CHATTANOOGA, TN

Mr. COOPER. Good morning. I want to thank you for the opportunity of meeting with us this morning. As you've already indicated in the introductions, which I appreciate, I work in health care social work, and over the years have developed a special interest in the needs of the elderly in our society.

Let me comment that while conventional wisdom seems to emphasize the poor health of the elderly, the truth is really quite different.

Most elderly persons are physically and mentally healthy enough to care for themselves and function independently. They're able to maintain their own homes, shop and cook, participate in personal, family and community activities. I think it's significant to note that.

After saying that, however, it's also true that the elderly adults use more health care services relative to their numbers than of any other age group.

Persons over age 65 accounted for 12 percent of the population in 1984 but used nearly 31 percent of all personal health care resources.

The Medicare program is obviously critical in providing access to the services that are required and accounted. Medicare accounted for almost half, 48.8 percent of personal health care expenditures in that same year.

As you know, contrary to popular belief, Medicare was not designed to cover all medical services needed by the elderly. It simply wasn't designed that way. It was originally intended primarily to help in the treatment of acute conditions that might be improved; things like infectious diseases and broken bones.

The trouble is that the elderly, as we've seen here, are most likely to suffer from chronic health care problems which require long term care.

Medicare, as a program, covers few long term care services. Even those it does cover, such as skilled nursing care and home care, are limited and reimbursed only if they're oriented towards a cure rather than care.

Other medical and medically related services or needs are not covered at all; eye glasses, dental care, prescription drugs and so on.

So the Medicare program is not and was not designed to be comprehensive in nature and was not designed to meet all the health care needs that are related to aging and chronic illness.

Beyond the limited coverage or non-coverage for some directly medical related items or services, the physically compromised elderly need services to compensate for their losses. Such services as access to assisted living, something different from nursing, from nursing home care, homemaker and chore services, trying to get home delivered meals, adult day care, respite care, sitter services, case and care management services.

These services, because they're related to physical loss of functioning and not a specific medically defined medical diagnosis, have not traditionally been addressed at all by the Medicare program. They don't fall under the notion of medically necessary services.

And medical necessity is the basic concept in differentiating that which is considered appropriate for coverage and that which is considered not appropriate for coverage.

I might go back and comment, since I have passed by some things.

When we see folks in the hospital who have had a significant change, stroke or whatever, in their living situation, and they bump up against the first time having to look at what kind of coverage there is, they presume oftentimes that there's much coverage available to them under Medicare including nursing coverage that simply is not there.

And one of the real difficulties engaging in any discharge planning process is to establish credibility with the person, that you know what you're talking about. And when they have absolutely convinced them the coverage is there, the difficulty is that they may just decide you don't know what you're talking about.

Senator SASSER. I might interrupt you to say that I've seen polling data that indicates that some 80 to 90 percent of the public believes that Medicare covers their long term health care cost including nursing home. And of course, that's simply not the case.

Mr. **Cooper**. That's correct. And when you engage someone, one of the things that you begin to do is to try to then educate them as to what kinds of coverages and resources are available to the individual as to what the circumstances are, is when in fact they don't understand what coverage they've got. And then you have to establish credibility that in fact you have something to say that could be helpful.

Some folks simply can't take the information in at that point. And what has to occur then is that you buy time to walk them into the system so that they can find out for themselves, gain confirmation, and then come back and say, gee, you were right, it's not there.

Some people just don't make it, and run into the system headlong without adequate planning. They experience the frustrations of dealing with a system that they simply can't understand and haven't been prepared for.

I think as a beginning point of any true medicare reform, is the need to recognize that Medicare has to be reshaped to deal with chronic care needs as a starting point, and that the concept of medical necessity that I refer to is really much too narrow and limiting.

I'm pleased that the proposal for Part C that I read from, in your regard, moves well in that direction in providing coverages that are simply not traditionally looked at now. Additionally, it provides needed long term care and institutional services when they're required.

I might note here that my father has required nursing home care for over the past 4 years due to increasing frailty, with frequent falls, eventual loss of ability and finally increasing dementia.

Not one night of his nursing home care today has been covered by Medicare because it simply doesn't fall under the definition for skilled care.

He has now, incidentally, used up all of his resources. And as of the past few months, we have made application for the eligibility of Medicaid.

And that's not an unusual pattern. That's a personal experience but also some experiences that we see on a repeated basis in the hospital setting.

So in long term care they use up the resources. Incidentally, I heard the figure used of $1,800. We figure that he has used up approximately, of his estate, approximately $100,000 in the past 4 or 5 years time.

Senator **Sasser**. Over what period of time?

Mr. **Cooper**. Approximately the past 4 plus years. It's been a few months beyond 4 years. But going in he had about $100,000 available to him, and essentially that has been eaten up.

I think it's clear that the long term care issue needs to be included under some kind of an ongoing coverage that folks have access to. I think that's a critical need.

I think also the inclusion of those nontraditional services, the things that are needed to maintain the person at home and to support the family's maintenance of that person at home, need to be looked at in terms of provisions of coverage. And then finally case management kinds of services I think need to be included there also.

In addressing long term care, steps, it seems to me, need to be taken to protect the spouse from being rendered destitute.

I have to tell you that when I was typing this into my nice computer machine last night and it bombed on me, so I had to rewrite it.

And I had in there some discussion of our own personal family situation. And I had a line that I decided should not be used, but I guess it should; that is, I suppose under our personal circumstances we were lucky that my mother's death preceded my father's total deterioration because she would have been left destitute by the situation and could have eventually, we would hope, qualify for SSI. Because if she had slightly too much income to qualify for SSI, then she would not even qualify for the Medicaid help.

In their case, my parents' case, they have seven children and I think that my mother would have been taken care of anyway. But I also know that it would've been very difficult for her to enter into a situation where she would accept that kind of support.

At any rate, it seems to me that those are major areas that need to be looked at in any Medicare reform.

I appreciate the opportunity of discussing those with you.

Senator SASSER. Well, thank you very much, Mr. Cooper. Let me ask you this question. In your experience with the medical community is there a difference in the way that our older citizens are treated medically as opposed to the way middle-aged younger citizens are treated?

Mr. COOPER. I'm not sure where you're headed with that. If you mean in terms of——

Senator SASSER. In regard to the responsiveness of the medical profession to their illnesses, to their complaints. Tell us what you've observed, if anything, in that regard.

Mr. COOPER. That's kind of an awkward question.

There are some physicians that have a very real interest in aging and the aging process. But your opening remarks are also very true, that the rewards of dealing with the aging client with a chronic disease, for the physician, it would seem to me from my observation anyway, don't encourage you to have that kind of ongoing long term interest.

We had some experience at Erlanger of attempting to—there is no geriatrician in the Chattanooga community.

Senator SASSER. Well, I'm not surprised at that. We're only going to have three geriatricians accredited or graduated this year in the whole of the United States. So I'm not surprised there's not one in Chattanooga.

Mr. COOPER. We recognize the need for that also, and looked for about 2 years to see what could be done to attract someone to come to Chattanooga, and were unsuccessful in being able to find someone.

To jump back over to your second bill. It also makes a comment about the rewards of dealing with the chronic care condition and needs of the elderly. And folks in nursing homes in particular I think have difficulty in—it may not be the interest in following a patient into the nursing home and what not.

And so there's a point at which many times decisions have to be made about changing physicians at that point and so on and so forth. I don't think that there's any question that there's not much desire to follow the elderly patient and the chronic deteriorating.

Senator SASSER. I don't think there's any doubt about it. And many physicians will simply say in response to complaints from elderly patients, "Well, that's a part of getting old." I remember them telling my father that. And the truth is that what he was suffering from was not part of getting old. But what he suffered from was the inattention of the physicians because they didn't want to deal with an older person. And we see a lot of that.

And that's one of the reasons that I want to establish these, this center, geriatric centers for excellence.

Do you believe, Mr. Cooper, that the establishment of centers for geriatric excellence across the country will be helpful in encouraging young physicians to get into the field of geriatrics and develop an expertise and interest in treating the illnesses of our elderly people?

Mr. COOPER. I have absolutely no doubt about it. I think that would be one thing that would be very, very helpful and focused.

There are a few centers that are available currently in the country, a few places that are recognized. And the only thing they can do is allow some support, I suppose out of the peer group, of that kind of interest and stimulate some general interest and research and begin to focus attention on that whole area.

Senator SASSER. Well, Mr. Cooper, I want to thank you and the rest of our witnesses for your testimony here today.

Just let me say that the testimony we received here today, I think, paints a vivid picture of the desperate problem that many of our older citizens are facing today and will face in the future.

Many of them now know that they can be financially devastated virtually overnight, and they now know that the $40,000 or $50,000 that many of them manage to set aside over the working lifetime can be dissipated in a matter of a couple of years if there is a serious illness.

I think the Federal Government together with the State government must do a better job in seeing to it that the medical needs of our elderly are attended to.

I think we do know that some medigap policies offer reasonable supplemental benefits for our older citizens. But the truth is that a great many of those medigap policies that are really of little or no assistance to our older population.

We should do a better job, I think, of educating the public as to that. We've got to do a better job of educating them as to what Medicare covers and does not cover. Otherwise a large portion of our population will continue to labor under the misapprehension that everything's going to be okay—Medicare's going to take care of it when they grow old. That's simply not the case in many instances.

I want to thank all of our witnesses today. These hearings are helpful and serve the role, as I indicated earlier, of informing the public of this grave problem.

And before we can move forward in our democratic system with really fundamental pieces of legislation, there has to be substantial public support for it, grass root support. We've used this past week going around the state and holding these hearings so that people can learn from the problems and the tragedies of others and thereby garner substantial public support for a substantial change in the Medicare system of this county.

Thank all of you for attending. The Subcommittee stands adjourned.

[Whereupon, the Subcommittee adjourned to reconvene at the call of the Chair.]

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

100TH CONGRESS
1ST SESSION

S. 454

To amend title XVIII of the Social Security Act to provide for a part C program to furnish comprehensive catastrophic and preventive benefits through prepaid plans.

IN THE SENATE OF THE UNITED STATES

FEBRUARY 4, 1987

Mr. SASSER introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend title XVIII of the Social Security Act to provide for a part C program to furnish comprehensive catastrophic and preventive benefits through prepaid plans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Medicare Part C: Catastrophic Health Insurance Act of 1987".

SEC. 2. NEW PART C.

(a) IN GENERAL.—Title XVIII of the Social Security Act is amended—

(1) by redesignating part C as part D, and

(2) by inserting after part B the following new part:

"PART C—PROGRAM FOR COMPREHENSIVE CATASTROPHIC COVERAGE AND CERTAIN PREVENTIVE BENEFITS

"ESTABLISHMENT OF PROGRAM

"SEC. 1851. There is hereby established a program to provide supplementary benefits in accordance with the provisions of this part for individuals entitled to benefits under part A through enrolling with an organization which has a contract with the Secretary under such program, to be financed from premium payments by enrollees together with transfers of amounts that otherwise would have been expended under parts A and B.

"CONTRACTS WITH ORGANIZATIONS TO PROVIDE COMPREHENSIVE MEDICARE BENEFITS

"SEC. 1852. (a) IN GENERAL.—Subject to the succeeding provisions of this part, the Secretary may enter into a contract with a public or private organization to provide comprehensive benefits to individuals enrolled with the organization under this part in return for payment on a capitated basis.

"(b) DESCRIPTION OF GENERAL MINIMUM BENEFITS.—A contract with an organization under this part must provide that the organization will provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI, the following items and services:

"(1) PART A AND B SERVICES WITHOUT DEDUCTIBLES, COPAYMENTS, COINSURANCE, OR RESTRICTIONS ON INPATIENT DAYS.—All the services covered under parts A and B, and, for this purpose and with respect to such services—

"(A) no deductible, copayment, or coinsurance may be imposed,

"(B) no restriction, under section 1812, on the number of days of benefits for inpatient hospital services or extended care services shall apply,

"(C) extended care services shall be covered whether or not they are post-hospital, and

"(D) the provisions of sections 1814(a)(2)(C) and 1835(a)(2)(A) shall not apply, insofar as they require, with respect to the provision of home health services, that an individual needs or needed skilled nursing care on an intermittent basis.

"(2) ANNUAL PREVENTIVE CARE VISITS.—Diagnostic procedures performed during an annual physical examination, including (as appropriate by sex) a routine Papanicolaou test for diagnosis of uterine cancer, blood pressure test, blood test for cholesterol levels, colorectal exam, and a mammogram.

"(3) ROUTINE EYE CARE.—

"(A) VISION EXAMINATIONS.—

"(i) IN GENERAL.—Subject to clause (ii), vision examinations, including—

"(I) case history,

"(II) external examination of the eyes and adnexa,

"(III) ophthalmoscopic examination,

"(IV) determination of refractive status,

"(V) binocular balance testing,

"(VI) tonometry test for glaucoma when indicated, and

"(VII) prescription for corrective lenses if indicated,

but which need not exceed one such examination for an individual in any 12-month period.

"(ii) LIMITATION.—Clause (i) requires inclusion of low-vision examinations only when (I) best corrected vision in the better eye does not equal 20/70 but is better than light perception or light projection or (II) vision field is restricted to 30 degrees or less, and only when provided by an ophthamologist or optometrist who is qualified (as determined by the Secretary) to provide such an examination.

"(B) EYEGLASSES.—

"(i) IN GENERAL.—Subject to clause (ii), dispensing (by an ophthamologist, optometrist, or optician licensed to dispense eyeglasses in the State in which the eyeglasses are dispensed) of prescription eyeglasses, including—

"(I) facial measurement and determination of interpupillary distance,

"(II) assistance in selection of frames,

"(III) procurement of quality frames and lenses,

"(IV) fitting and adjustment of eyeglasses, and

"(V) periodic refitting and adjustment of eyeglasses,

but which need not exceed the dispensing of a single set of eyeglasses for an individual more often than once in any 12-month period.

"(ii) Limitation.—Clause (i) only requires provision of eyeglasses with respect to an individual if a vision examination described in subparagraph (A) has determined that the individual's vision, through the use of conventional eyeglasses, can be corrected to a normal level of sight (as specified by the Secretary).

"(4) Dental care.—

"(A) In general.—Dental services (other than those described in subparagraph (B)), including—

"(i) teeth cleaning, whether performed by a dentist or by a licensed dental hygienist under the order or supervision of a dentist, but which need not exceed one cleaning in any 12-month period;

"(ii) radiographs (other than for purposes of endodontic therapy), but which need not exceed one full series in any 12-month period, and a panographic radiograph in the case of an edentulous individual;

"(iii) a dental examination, including an evaluation for oral cancer or oral pathology, a dental tissue examination (with charting of caries and defective restorations), and a periodontal evaluation of existing teeth;

"(iv) tooth extractions;

"(v) simple restorations;

"(vi) services (including necessary crowns and bridges) required for the furnishing of—

"(I) full or partial dentures (meeting standards established under subparagraph (B)), but which need not exceed one complete set (or the replacement, repair, rebasing, or relining of such dentures) every 5 years,

"(II) over dentures, and

"(III) the use of temporary, partial dentures pending extraction of teeth for full dentures;

"(vii) surgical preparation of edentulous ridges (but which need not be done more often than once every 5 years);

"(viii) periodontal therapy; and

"(ix) endodontics.

"(B) PERMISSIBLE EXCLUSIONS.—Dental services need not include—

"(i) orthodontic care;

"(ii) crown and bridgework beyond such extent as the Secretary may provide;

"(iii) cosmetic surgery or dentistry; or

"(iv) the furnishing of dentures unless—

"(I) the dentures furnished have been certified by the Secretary to meet such quality standards as the Secretary establishes, and

"(II) the dentures are inscribed with the name or other identification of the individual for whom the dentures are made.

"(C) INSCRIPTION SERVICES.—Dental services also include the inscription (described in subparagraph (B)(iv)(II)) on dentures of the name or other identification of an individual, in the case of dentures made before the effective date of this part.

"(5) HEARING CARE.—Hearing examinations and aids as follows:

"(A) THRESHOLD TEST.—A hearing threshold test, conducted by a physician or qualified audiologist, but which need not occur more often than once every 2 years.

"(B) HEARING-IMPAIRED INDIVIDUALS.—For an individual determined to have a significant communicative difficulty—

"(i) a comprehensive audiometric assessment by a physician or qualified audiologist, but which need not occur more often than once every 2 years;

"(ii) if the individual is determined (as a result of such an assessment) to have a difficulty which can be appropriately treated with a hearing aid—

"(I) a hearing aid assessment by a physician or qualified audiologist in order to determine the appropriate hearing aid to be dispensed,

"(II) the dispensing by a physician, qualified audiologist, or hearing aid dealer of a hearing aid and instruction on its use, except that dispensing of such a hearing aid need not occur more often than once in any 3-year period and need not include any batteries required for use of such hearing aid or any repairs which such aid may require, and

"(III) if the hearing aid is furnished by a hearing aid dealer, a post-fitting examination and orientation by a physician or qualified audiologist; and

"(iii) if the individual is determined (as a result of such an assessment) to have a difficulty which cannot be appropriately treated with the provision of a hearing aid but can be appropriately treated through aural rehabilitative instruction, the provision of such instruction by a qualified audiologist, which need not exceed 4 hours for any individual during the individual's lifetime.

For purposes of subparagraph (B), an individual has a significant communicative difficulty if the individual is determined, under the test described in subparagraph (A), to have pure tone hearing thresholds at 500, 1000, 2000, and 3000 hertz in both ears of not greater than 25 decibels, when averaged across such frequencies.

"(6) LONG-TERM CARE SERVICES.—Comprehensive long-term care services provided in the environment of least restriction. Such services shall be approved and regularly recertified by a geriatric assessment team (including a physician, a geriatric nurse, and social worker) and be provided on a case-managed basis. Such services shall include adult day care services, intermediate care facility services, home and community-based services, outpatient drug therapy, and respite care.

"(7) HEALTH PROMOTION AND DISEASE PREVENTION INFORMATION.—Information, as developed by the Secretary, designed so as to promote healthy lifestyles (including diet and exercise) and to promote disease prevention (including self-monitoring and regular utilization of annual preventive care visit benefit described in paragraph (2)). Such information shall be provided in a form which is easily understood by beneficiaries.

"(c) CERTIFICATION OF SAFETY AND EFFICACY OF HEARING AIDS.—The Secretary shall provide for a program for the certification of the safety and efficacy of hearing aids for which payment may be made under this part. Under such program, a hearing aid may not be certified unless—

"(1) the aid has been determined to be safe and effective in the treatment of the hearing difficulty for which it is to be used; and

"(2) the manufacturer or supplier of such aid provides a warranty against failure of the aid to operate during at least the first year after the date the aid is initially dispensed.

"(d) ADDITIONAL PROVISIONS RELATING TO BENEFITS.—

"(1) REQUIREMENT OF ADDITIONAL BENEFITS IN CERTAIN CASES.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), each such contract shall provide that if—

"(i) the adjusted community rate, as defined in section 1876(e)(3), for required services described in subsection (b) for members enrolled under this part with the organization is less than—

"(ii) the average of the per capita rates of payment to be made under subsection (f) at the beginning of an annual contract period for such members,

the organization shall provide to such members additional health benefits which are selected by the organization and which the Secretary finds are at least equal in value to the difference between that average per capita payment and the adjusted community rate. If the Secretary finds that there is insufficient enrollment experience to determine an average of the per capita rates of payment to be made under subsection (f) at the beginning of a contract period, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this section.

"(B) RESERVATION OF ADDITIONAL BENEFITS.—An organization (with the approval of the Secretary and during a period of not longer than 4 years) may provide that a part of the value of the additional benefits otherwise required to be provided by reason of subparagraph (A) be withheld and reserved in the Federal Medicare Part C Trust Fund by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with such subparagraph. Any of such value of additional benefits which is not provided to members of the organization in accordance with such subparagraph prior to the end of such period, shall revert for the use of such trust fund.

"(2) ADDITIONAL OPTIONAL SERVICES.—A contract with an organization may also provide for such additional services as the Secretary may approve. The Secretary shall approve any such additional health care services which the organization proposes to offer to such members, unless the Secretary determines that including such additional services will substantially discourage eligible individuals' enrollment with the organization under this part.

"(3) GENERAL REQUIREMENT OF AVAILABILITY AND ACCESSIBILITY OF SERVICES.—Under a contract under this section, an organization must—

"(A) make services offered to members enrolled under the contract—

"(i) available and accessible within the area served by the organization, with reasonable promptness and in a manner which assures continuity and (for services covered under part A or under part B) with access at least to the same extent as such services are made accessible to individuals who are entitled to benefits under part A (and enrolled under part B) but who are not enrolled under such a contract, and

"(ii) when medically necessary, available and accessible 24 hours a day and 7 days a week, and

"(B) provide for reimbursement with respect to such services which are provided to such an individual other than through the organization, if—

"(i) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition, and

"(ii) it was not reasonable given the circumstances to obtain the services through the organization.

"(e) Enrollment and Charges for Premiums, Deductibles, Coinsurance, Etc.—

"(1) Enrollment.—An organization must provide for enrollment of members under this part in accordance with section 1853.

"(2) No additional premiums, deductibles, etc.—An organization may not charge any premiums, deductibles, coinsurance, copayments, or other amounts for services provided to individuals under contracts under this section.

"(f) Capitated Payment to Organizations.—

"(1) Monthly payments to organizations.—In the case of an organization with a contract under this section, the Secretary shall make monthly payments in advance and in accordance with the rate determined under paragraph (2)(C) to the organization for each individual whose enrollment with the organization is effective under this part.

"(2) DETERMINATION OF CAPITATION AMOUNTS.—

"(A) IN GENERAL.—The Secretary shall annually determine, and shall publish not later than September 7 before the calendar year concerned, a per capita rate of payment for each class of individuals who are enrolled under this part.

"(B) CLASSES OF ENROLLEES.—For purposes of this paragraph, the classes of individuals shall be the same as the classes defined under section 1876(a)(1)(B).

"(C) PER CAPITA RATES OF PAYMENT.—The annual per capita rate of payment for each such class shall be equal to 133 percent of the payment amount that would be made under section 1876(a) under a risk-sharing contract with respect to that class if '100 percent' were substituted for '95 percent' in section 1876(a)(1)(C) and if section 1876(g)(2) did not apply.

"(3) PAYMENT ADJUSTMENTS.—The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals whose enrollment with the organization under this part is effective and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment. The amount of such payment shall also be increased, in the case of an individual enrolled under this part under section 1854(c), by an amount equal to the difference between the premium amount established under section 1854(c)(2) with respect to the individual and the per capita rate otherwise determined under paragraph (2).

"(4) RECOVERY FOR THIRD-PARTY LIABILITY.—Notwithstanding any other provision of law, the organization may (in the case of the provision of services to a member enrolled under this part for an illness or injury for which the member is entitled to benefits under a workmen's compensation law or plan of the United States or a State, under an automobile or liability insurance policy or plan, including a self-insured plan, or under no fault insurance) charge or authorize the provider of such services to charge, in accordance with the charges allowed under such law or policy—

"(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

"(B) such member to the extent that the member has been paid under such law, plan, or policy for such services.

"(5) PAYMENTS IN LIEU OF OTHER PAYMENTS UNDER TITLE.—Subject to paragraph (6)—

"(A) payments under a contract to an organization under this part shall be instead of the amounts which (in the absence of the contract) would be otherwise payable, pursuant to sections 1814(b), 1833(a), and 1876(a), for services furnished by or through the organization to individuals enrolled with the organization under this part; and

"(B) if an individual is enrolled under this part with an organization having a contract, only the organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

"(6) FINANCIAL RESPONSIBILITY FOR PATIENTS HOSPITALIZED ON THE EFFECTIVE DATE OF ENROLLMENT OR TERMINATION.—A contract under this part shall provide that in the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) or through an organization as of the effective date of the individual's—

"(A) enrollment with an organization (or another organization) under this part—

"(i) payment for such services until the date of the individual's discharge shall be made under this title as if the individual were not enrolled with that organization (or subsequent organization),

"(ii) the organization (or subsequent organization) shall not be financially responsible for payment for such services until the date after the date of the individual's discharge, and

"(iii) the organization (or subsequent organization) shall nonetheless be paid the full amount otherwise payable to the organization under this part; or

"(B) termination of enrollment with an organization under this part—

"(i) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge, "(ii) payment for such services during the stay shall not be made under section 1886(d), and

"(iii) that organization shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

"(7) ADEQUATE ASSURANCES AGAINST RISK OF INSOLVENCY.—The Secretary may not enter into a contract with an organization under this section unless the Secretary has received satisfactory assurances that the organization has made adequate provision against the risk of insolvency, which provision is satisfactory to the Secretary and which assures that individuals enrolled with the organization under this part are in no case held liable for debts of the organization in case of the organization's insolvency.

"(8) PROMPT PAY REQUIREMENT—

"(A) IN GENERAL.—A contract under this part shall require the organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and and supplies furnished to individuals pursuant to such contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier.

"(B) ENFORCEMENT.—In the case of an organization which the Secretary determines, after notice and opportunity for a hearing, has failed to make payments of amounts in compliance with subparagraph (A), the Secretary may provide for direct payment of the amounts owed to providers and suppliers for such covered services furnished to individuals enrolled under this part under the contract. If the Secretary provides for such direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this part to reflect the amount of the Secretary's payment (and costs incurred by the Secretary in making such payments).

"(g) QUALITY CONTROL AND GRIEVANCE PROCEDURES.—

"(1) GRIEVANCE PROCEDURES.—

"(A) BY ORGANIZATION.—The organization must provide, in its contract under this section, meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and members enrolled with the organization under this part.

"(B) Appeal to local review boards.—A member enrolled with an organization under this part who is dissatisfied by reason of his failure to receive any health service to which he believes he is entitled and at no greater charge than he believes he is required to pay is entitled to a hearing (in a form and manner prescribed by the Secretary) before a local review panel which has been established in accordance with regulations of the Secretary and at least one-half of the membership of which is composed of representatives of individuals entitled to benefits under part A and enrolled under part B.

"(C) Members' appeals rights.—A member enrolled with an organization under this part who, after being provided a hearing under subparagraph (B), is still dissatisfied by reason of his failure to receive any health service to which he believes he is entitled and at no greater charge than he believes he is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is $1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the organization shall be entitled to be parties to that judicial review.

"(2) QUALITY CONTROL.—

"(A) ARRANGEMENTS.—In order to enter into a contract under this section, each organization must have arrangements, established in accordance with regulations of the Secretary, for an ongoing quality assurance program for health care services it provides to such individuals, which program (i) stresses health outcomes, (ii) provides for the review of the credentials of physicians and allied health professionals, and (iii) provides review by physicians and other health care professionals of the process followed in the provision of such health care services.

"(B) PRO REVIEW.—Peer review organizations, with contracts under part A of title XI, have the responsibility of reviewing the quality of and access to services furnished by organizations under contracts entered into under this section. Such contracts shall not be terminated with respect to such quality review unless the Secretary has provided for the performance of such quality review under another contract with a peer review organization. In performing such review with respect to long-term care services, a peer review organization shall use physicians with expertise in geriatrics and other health professionals with expertise in geriatrics and long-term care.

"(C) SECRETARIAL REVIEW.—The Secretary annually shall review the quality of, and access to, services provided under each contract entered into under this section in order to meet the requirements of subsection (c)(3) and to assure that services provided meet professionally recognized standards of health and long-term care.

"(h) MISCELLANEOUS TERMS AND CONDITIONS.—

"(1) PERIOD AND GROUNDS FOR TERMINATION.—Each contract under this section shall be for a term of at least one year, as determined by the Secretary, and may be made automatically renewable from term to term in the absence of notice by either party of intention to terminate at the end of the current term; except that the Secretary may terminate any such contract at any time (after such reasonable notice and opportunity for hearing to the organization involved as he may provide in regulations), if he finds that the organization—

"(A) has failed substantially to carry out the contract,

"(B) is carrying out the contract in a manner inconsistent with the efficient and effective administration of this part, or

"(C) no longer substantially meets the applicable conditions of this part.

"(2) EFFECTIVE DATE.—The effective date of any contract executed pursuant to this section shall be specified in the contract.

"(3) AUDITING AND MISCELLANEOUS PROVISIONS.—Each contract under this section—

"(A) shall provide that the Secretary, or any person or organization designated by him—

"(i) shall have the right to inspect or otherwise evaluate (I) the quality, appropriateness, and timeliness of services performed under the contract and (II) the facilities of the organization when there is reasonable evidence of some need for such inspection, and "(ii) shall have the right to audit and inspect any books and records of the organization that pertain (I) to the ability of the organization to bear the risk of potential financial losses, or (II) to services performed or determinations of amounts payable under the contract;

"(B) shall require the organization to provide (and pay for) written notice in advance of the contract's termination, as well as a description of alternatives for obtaining benefits under this title, to each individual enrolled under this part with the organization;

"(C)(i) shall require the organization to comply with subsections (a) and (c) of section 1318 of the Public Health Service Act (relating to disclosure of certain financial information) and with the requirement of section 1301(c)(8) of such Act (relating to liability arrangements to protect members);

"(ii) shall require the organization to provide and supply information (described in section 1866(b)(2)(C)(ii)) in the manner such information is required to be provided or supplied under that section;

"(iii) shall require the organization to notify the Secretary of loans and other special financial arrangements which are made between the organization and subcontractors, affiliates, and related parties;

"(D) shall report to the Secretary information on the utilization of services by individuals enrolled under the contract; and

"(E) shall contain such other terms and conditions not inconsistent with this part (including requiring the organization to provide the Secretary with such other information) as the Secretary may find necessary and appropriate.

"(4) RESTRICTION ON RE-ENTERING INTO CONTRACTS.—The Secretary may not enter into a contract with an organization under this section if a previous contract with that organization under this section was terminated at the request of the organization within the preceding five-year period, except in circumstances which warrant special consideration, as determined by the Secretary.

"(5) CONTRACTUAL AUTHORITY.—The authority vested in the Secretary by this part may be performed without regard to such provisions of law or regulations relating to the making, performance, amendment, or modification of contracts of the United States as the Secretary may determine to be inconsistent with the furtherance of the purpose of this title.

"(6) AUTHORITY FOR CIVIL MONEY PENALTIES.—

"(A) IN GENERAL.—An organization with a contract under this part that fails substantially to provide medically necessary items and services that are required (under law or such contract) to be provided to individuals covered under such contract, if the failure has adversely affected (or has a substantial likelihood of adversely affecting) these individuals, is subject to a civil money penalty of not more than $10,000 for each such failure.

"(B) ENFORCEMENT.—The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under subparagraph (A) in the same manner as they apply to a civil money penalty under that section.

"ENROLLMENT OF MEMBERS

"SEC. 1853. (a) REQUIRED ENROLLMENT.—

"(1) IN GENERAL.—Subject to the provisions of subsection (b), every individual entitled to benefits under part A shall be enrolled under this part with any organization with which the Secretary has entered into a contract under this part and which serves the geographic area in which the individual resides.

"(2) EFFECTIVE DATE.—Paragraph (1) shall not apply to enrollment for periods beginning before the first calendar year that begins at least 3 years after the date of the enactment of this part, except as may be provided by the Secretary under section 2(b) of the Medicare Part C: Catastrophic Health Insurance Act of 1987.

"(b) OPEN ENROLLMENT.—

"(1) REQUIRED PERIOD.—Each organization must have an open enrollment period, for the enrollment of individuals under this part, of at least 30 days duration every year and including the 30-day period specified under paragraph (2), and must provide that at any time during which enrollments are accepted, the organization will accept up to the limits of its capacity (as determined by the Secretary) and without restrictions, except as may be authorized in regulations, individuals who are eligible to enroll under subsection (a) in the order in which they apply for enrollment, unless to do so would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the population in the geographic area served by the organization.

"(2) COORDINATED PERIODS.—For each area served by more than one organization under this part, the Secretary (after consultation with such organizations) shall establish a single 30-day period each year during which all organizations serving the area must provide for open enrollment under this part. An organization may provide for such other open enrollment period or periods as it deems appropriate consistent with this part.

"(c) ENROLLMENT.—

"(1) IN GENERAL.—Each eligible individual may enroll under this part with an organization in such manner as may be prescribed in regulations and may terminate his enrollment with the organization as of the beginning of the first calendar month following the date on which the request is made for such termination (or, in the case of financial insolvency of the organization, as may be prescribed by regulations). In the case of an individual's termination of enrollment—

"(A) the organization shall provide the individual with a copy of the written request for termination of enrollment and a written explanation of the period (ending on the effective date of the termination) during which the individual continues to be enrolled with the organization and may not receive benefits under this title other than through the organization, and

"(B) the individual shall specify the organization in which the individual will subsequently be enrolled under this part.

"(2) FAILURE TO DESIGNATE ENROLLMENT.—If an individual who is required to enroll with an organization under this part fails to so enroll or terminates such enrollment without enrolling with another organization, the Secretary shall provide for the enrollment of the individual with an organization in accordance with a system that provides for equal proportional enrollment among the qualified organizations.

"(3) PROVISION OF INFORMATION AT TIME OF ENROLLMENT AND ANNUALLY THEREAFTER.—Each organization shall provide each enrollee, at the time of enrollment and not less frequently than annually thereafter, an explanation (in a format approved by the Secretary under subsection (d)) of the enrollee's rights under this part, including—

"(A) the benefits to be provided by the organization to enrollees under this part, including the rights of appeal described in section 1852(e), "(B) the premiums required as a condition of enrollment, and

"(C) such other information as the Secretary may require.

"(d) DISSEMINATION OF INFORMATION.—The Secretary may prescribe the procedures and conditions under which an organization that has entered into a contract with the Secretary under this part may inform individuals eligible to enroll under this part with the organization about the organization, or may enroll such individuals with the organization. No brochures, application forms, or other promotional or informational material may be distributed by an organization to (or for the use of) individuals eligible to enroll with the organization under this part unless (1) at least 45 days before its distribution, the organization has submitted the material to the Secretary for review and (2) the Secretary has not disapproved the distribution of the material. The Secretary shall review all such material submitted and shall disapprove such material if the Secretary determines, in the Secretary's discretion, that the material is materially inaccurate or misleading or otherwise makes a material misrepresentation.

"(e) FAIR ENROLLMENT PRACTICES.—The organization must provide assurances to the Secretary that it will not expel or refuse to re-enroll any individual under this part because of the individual's health status or requirements for health care services, and that it will notify each such individual of such fact at the time of the individual's enrollment.

"(f) TERMINATION OF ENROLLMENT.—

"(1) LOSS OF ENTITLEMENT.—The Secretary shall provide for the termination of enrollment of an individual with an organization under this part at the time the individual loses entitlement to benefits under part A. Notwithstanding the previous sentence, an individual may again re-enroll with an organization at the time at which the individual again becomes entitled to benefits under part A.

"(2) FAILURE TO PAY PREMIUMS.—The Secretary shall provide for the termination of enrollment of an individual under this part for the individual's nonpayment of premiums required under section 1854. Such termination shall take effect on a date determined under regulations, which may be determined so as to provide a grace period in which overdue premiums may be paid and coverage continued. The grace period determined under the preceding sentence shall not exceed 120 days; except that it may be extended to not to exceed 270 days in any case where the Secretary determines that there was good cause for failure to pay the overdue premiums within such 120-day period.

"AMOUNTS AND PAYMENT OF PREMIUMS

"SEC. 1854. (a) AMOUNT OF PREMIUM.—

"(1) Computation of national average monthly payment rates.—The Secretary shall determine, at the time of determination of capitated rates under section 1852(e), the national average monthly payment rate, for each individual enrolled with an organization under this part, which the Secretary determines is likely to be paid to organizations during months in the succeeding calendar year.

"(2) Premium amount.—Except as provided in paragraphs (3) and (4) and subsection (c), the monthly premium of each individual enrolled under this part for each month in that succeeding calendar year is equal to 25 percent of the national average monthly rate determined under paragraph (1), reduced (in the case of an individual enrolled under part B) by the premium amount established under section 1839 (without regard to subsections (b) or (f)(2) thereof).

"(3) Limitation on premium.—

"(A) In general.—The monthly premium, for an individual for months in a calendar year, cannot exceed 1/12th of 15 percent of the individual's annual gross income for the previous calendar year.

"(B) Determination of annual gross income.—For purposes of this subparagraph (A), the Secretary, in consultation with the Secretary of the Treasury, shall establish rules for determining the annual gross income of an individual for a calendar year, and shall include in the definition of income both earned and unearned income.

"(4) NO ADDITIONAL PREMIUM.—An organization with a contract under this part may not impose any premium or other fee with respect to the enrollment of an individual with the organization under this part.

"(b) COLLECTION OF PREMIUM.—The payment of premiums under this part shall be made in the same manner as payment of premiums is made under part B, as determined under section 1840, except that—

"(1) all amounts so paid under this part shall be deposited in the Federal Medicare Part C Trust Fund,

"(2) during an individual's first enrollment with an organization under this part, the premiums must be paid for one month before the individual's enrollment with the organization becomes effective, and

"(3) any reference in section 1840 to an agreement entered into pursuant to section 1843 shall be deemed, for purposes of this subsection, to be a reference to such an agreement as entered into pursuant to subsection (c).

"(c) USE OF STATE AGREEMENTS.—In accordance with regulations, the Secretary shall enter into agreements with States in order to effect coverage of certain coverage groups under this part in the same manner as the Secretary has entered into agreements with States under section 1843, except that for this purpose—

"(1) there shall be no time limitations on States entering into agreements under this subsection,

"(2) the amount of premium to a State shall be equal to 90 percent of the estimated cost of providing similar services under its plan under title XIX, and

"(3) Secretary shall provide for such other appropriate modifications in the application of such section as may be appropriate to carry out this part.

In addition to any other requirement of law, the Secretary may not approve a State plan under title XIX (for any period during which the provisions of this part apply to residents of the State) unless the State has entered into and has in effect an agreement described in the previous sentence.

"(d) AGREEMENTS WITH OTHER GOVERNMENT ENTITIES.—The Secretary may enter into agreements (similar to the agreements described in subsection (c)) with Government entities (such as the Administrator of Veterans' Affairs) under which the Government entities will provide for the payment of the appropriate premiums under this part for individuals otherwise entitled to benefits health care through those Government entities.

"FEDERAL MEDICARE PART C TRUST FUND

"SEC. 1855. (a) ESTABLISHMENT.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Medicare Part C Trust Fund' (hereinafter in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this section.

"(b) INCORPORATION OF SIMILAR PROVISIONS.—The provisions of subsections (b) through (i) of section 1841 shall apply to the Trust Fund in the same manner as they apply to the Federal Supplementary Medical Insurance Trust Fund.

"(c) PAYMENT OF ORGANIZATIONS.—The payment to an organization under section 1852(e) for individuals enrolled under this part with the organization shall be made from the Federal Medicare Part C Trust Fund.

"(d) TRANSFER OF FUNDS TO TRUST FUND.—With respect to an individual enrolled with an organization under this part, the Secretary shall provide for transfer to the Federal Medicare Part C Trust Fund from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund of the same amounts, and in the same proportions, from each such trust fund as would be paid under section 1876(a)(5) if the individual were enrolled with an eligible organization under a risk-sharing contract under section 1876 and if '100 percent' were substituted for '95 percent' in section 1876(a)(1)(C).".

(b) EFFECTIVE DATE.—

(1) CONTRACTS.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall enter into contracts under part C of title XVIII of the Social Security Act (as inserted by subsection (a)) with respect to services to be furnished in calendar years beginning 3 or more years after the date of enactment of this Act.

(B) EARLY, PHASED-IN IMPLEMENTATION.—In order to permit the phased-in implementation of part C of title XVIII of the Social Security Act, the Secretary may enter into such contracts with respect to services to be furnished in one or more States in calendar years beginning at least 1 year (but less than 3 years) after the date of the enactment of this Act.

(2) MANDATORY ENROLLMENT.—

(A) IN GENERAL.—Before the first calendar year which begins 3 years after the date of the enactment of this Act, except as provided in subparagraph (B), no individual is required, under part C of title XVIII of the Social Security Act, to be enrolled with an organization under that part or to be liable for premiums under such part.

(B) EARLIER ENROLLMENT REQUIRED.—If the Secretary under paragraph (1)(B) has entered into contracts in a State for a calendar year before the first calendar year referred to in subparagraph (A), the Secretary may provide that part C of title XVIII of the Social Security Act shall apply to individuals residing in the State as of first calendar year in which such contracts are in effect and such individuals (in accordance with regulations of the Secretary) shall be enrolled with such organizations and shall be liable for premiums under such part beginning with that calendar year.

SEC. 3. STATE MAINTENANCE OF EFFORTS FOR MEDICAL ASSISTANCE FOR MEDICARE-ELIGIBLE MEDICALLY NEEDY INDIVIDUALS.

Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by inserting after subsection (r) the following new subsection:

"(s)(1) Notwithstanding any other provision of this section, the amount of funds to which a State is entitled under subsection (a)(1) with respect to calendar quarters in a fiscal year shall be reduced by the amount by which—

"(A) the total expenditures described in subsection (a)(1) which the Secretary estimates the State would have made for medical assistance for medicare-eligible medically needy individuals during such quarters under the State plan if (i) the plan were the same as the plan in effect on January 1, 1987, and (ii) any effect of the enactment of the Medicare Part C: Catastrophic Health Insurance Act of 1987 were eliminated; exceeds

"(B) the total expenditures described in subsection (a)(1) which the Secretary estimates the State has made for medical assistance for medicare-eligible medically needy individuals during such quarters.

"(2) In paragraph (1), the term 'medicare-eligible medically needy individual' means an individual who is entitled to benefits under parts A and C of title XVIII and who is not described in section 1902(a)(10)(A).".

SEC. 4. MISCELLANEOUS TECHNICAL AND CONFORMING AMENDMENTS.

(a) Social Security Act.—(1) Sections 226(c)(1) of the Social Security Act (42 U.S.C. 426(c)(1)) and section 7(d)(1) of the Railroad Retirement Act of 1974 (45 U.S.C.

231f(d)(1)) are each amended by striking "part C" and inserting in lieu thereof "part D".

(2) Sections 201(g)(1)(A) and 201(i)(1) of the Social Security Act (42 U.S.C. 401(g)(1)(A), 401(i)(1)) are each amended (A) by striking "and" before "the Federal Supplementary" and inserting in lieu thereof a comma, and (B) by inserting "and the Federal Medicare Part C Trust Fund" after "Medical Insurance Trust Fund".

(3) Section 1106(b) of such Act (42 U.S.C. 1306(b)) is amended by striking "and the Federal Supplementary Medical Insurance Trust Fund" and inserting in lieu thereof "the Federal Supplementary Medical Insurance Trust Fund, and the Federal Medicare Part C Trust Fund".

(4) Section 1124(a)(2) of such Act (42 U.S.C. 1320a–3(a)(2)) is amended—

(A) by striking "or" at the end of subparagraph (B),

(B) by striking the period at the end of subparagraph (C) and inserting in lieu thereof "; or", and

(C) by adding at the end the following new subparagraph:

"(D) an organization with a contract with the Secretary under part C of title XVIII.".

(5) Section 1126(a) of such Act (42 U.S.C. 1320a–5(a)) is amended by inserting "(including an organization with a

contract under part C of title XVIII)" after "agency" the first place it appears.

(6) Section 1814(a) of such Act (42 U.S.C. 1395f(a)) is amended, in the matter before paragraph (1), by striking "and in section 1876" and inserting ", in section 1876, and in part C".

(7) Section 1833(a) of such Act (42 U.S.C. 1395l(a)) is amended, in the matter before paragraph (1), by inserting "and in part C" after "in section 1876".

(8) Section 1861(s)(2)(H)(i) of such Act (42 U.S.C. 1395x(s)(2)(H)(i)) is amended by inserting "or under part C" after "section 1876".

(9) Section 1861(s)(2)(H)(ii) of such Act (42 U.S.C. 1395x(s)(2)(H)(ii)) is amended by inserting "or a contract under part C" after "section 1876(g)".

(b) **Other Act.**—Section 104(b) of the Social Security Amendments of 1965 is amended by inserting "or part C" after "part B" each place it appears.

100TH CONGRESS
1ST SESSION

S. 1112

To amend the Public Health Service Act to provide for the development of academic leaders in geriatrics through the establishment of centers of excellence in geriatric research and training.

IN THE SENATE OF THE UNITED STATES

APRIL 29 (legislative day, APRIL 21), 1987

Mr. SASSER (for himself, Mr. DURENBERGER, Mr. KERRY, Mr. HEINZ, and Mr. GLENN) introduced the following bill; which was read twice and referred to the Committee on Labor and Human Resources

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A BILL

To amend the Public Health Service Act to provide for the development of academic leaders in geriatrics through the establishment of centers of excellence in geriatric research and training.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That this Act may be cited as the "Centers of Excellence in Geriatric Research and Training Act of 1987".

FINDINGS AND PURPOSE

SEC. 2. (a) The Congress finds that—

(1) recent growth and projected growth in the number of elderly individuals in the United States

raises concerns about how best to meet the health care needs of such individuals;

(2) providing high quality health care for elderly individuals requires special knowledge about the clinical syndromes and psychological changes related to aging;

(3) recent studies show that there is a serious shortage of physicians in the United States with adequate knowledge concerning geriatrics;

(4) unless positive national action is taken, the current shortage of trained geriatricians will grow even worse as the number of older Americans dramatically increases over the next several decades;

(5) the shortage of trained geriatricians is a result of inadequate training and research opportunities at all levels of medical education;

(6) although 75 percent of American medical schools currently offer elective courses in geriatrics, only about 4 percent of medical students take these courses;

(7) in the 1986–1987 academic year, there were no geropsychiatrists in advanced training in the United States and only three geriatricians in such training;

(8) in order to provide adequate health care for the rapidly increasing number of elderly Americans, it

is important first to train a sufficient number of academic leaders in geriatrics who will, in turn, train sufficient numbers of physicians to care for elderly individuals;

(9) the training of geriatricians in the United States can be greatly improved by establishing centers of excellence in geriatric research and training; and

(10) such centers must have excellent faculty and support personnel as well as strong research, clinical, and educational components.

(b) It is the purpose of this Act to—

(1) expand the authority of the National Institute on Aging to develop academic leaders in geriatrics; and

(2) authorize the establishment of centers of excellence in geriatric research and training to develop such leaders.

ESTABLISHMENT OF CENTERS

SEC. 3. (a) Subpart 5 of part C of title IV of the Public Health Service Act is amended by adding at the end thereof the following new section:

"CENTERS OF EXCELLENCE IN GERIATRIC RESEARCH AND TRAINING

"SEC. 445A. (a) The Director of the Institute shall enter into cooperative agreements with, and make grants to, public and private nonprofit entities to pay all or part of the costs of the development or substantial expansion of centers of excellence in geriatric research and training. Each center developed or expanded under this section shall—

"(1) utilize the facilities of a single institution, or be formed from a consortium of cooperating institutions, meeting such research and training qualifications as may be prescribed by the Director; and

"(2) conduct—

"(A) research into the aging processes and into the diagnosis and treatment of diseases, disorders, and complications related to aging;

"(B) advanced training programs in current methods of diagnosis and treatment of such diseases, disorders, and complications;

"(C) programs to develop individuals capable of conducting research concerning aging and concerning such diseases, disorders, and complications; and

"(D) educational and training activities for students of the health professions in order to enhance the knowledge of such students in geriatrics.

"(b) Each center developed or expanded under this section shall place primary emphasis on training of physicians to provide training in geriatrics to other physicians and to students of the health professions.

"(c) In making cooperative agreements and grants under this section for the development or expansion of centers, the Director of the Institute shall provide that such centers are—

"(1) geographically distributed throughout the United States; and

"(2) located at entities with proven research capabilities.

"(d) The Director of the Institute shall evaluate on an annual basis the activities of centers developed or expanded under this section and shall report to the Congress (on or before September 30 of each year) the results of such evaluations.".

(b) Section 408(a) of such Act is amended by adding at the end thereof the following new paragraph:

"(3) For centers under section 445A, there are authorized to be appropriated—

"(A) $7,000,000 for the fiscal year 1988, which shall be available for the development or expansion of not more than five centers under such section for such fiscal year;

"(B) $11,000,000 for fiscal year 1989, which shall be available for the development or expansion of not more than seven centers under such section for such fiscal year; and

"(C) $15,000,000 for fiscal year 1990, which shall be available for the development or expansion of ten centers under such section for such fiscal year.".

AARP

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on

HEALTH CARE FOR THE ELDERLY

before

THE HONORABLE SENATOR JIM SASSER

Nashville, Tennessee

August 27, 1987

Presented by
Robert Maxwell

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700
John T. Denning *President* Cyril F. Brickfield *Executive Director*

Thank you, Senator Sasser. On behalf of the 26 million members of the American Association of Retired Persons, I wish to thank you for this opportunity to state the Association's views on the health care needs of older Americans, particularly as they relate to catastrophic illness, Medicare supplemental insurance, and the practice of geriatric medicine.

Before I begin, however, I would like to say that the Association is gratified by the current congressional and public interest in the problem of high cost illness and its impact on older Americans. We believe that the public debate on catastrophic illness itself is a critical step in the development of workable, appropriate solutions to a complex but hardly intractable social problem. I also want to commend you for having been the first to introduce legislation on this subject this year in the Senate.

I will focus my remarks this morning on three areas: (1) the financial burden older Americans face in dealing with high-cost illness; (2) the role of Medicare supplemental insurance in alleviating that financial burden on the elderly; and (3) the need for adequate numbers of appropriately trained health care providers to deliver medical care to older Americans.

I. THE CATASTROPHIC ILLNESS EXPERIENCE AMONG OLDER AMERICANS

Let us be clear this morning about the source of catastrophic costs for this country's senior citizens. Indisputably, the most critical need for catastrophic protection for older Americans is for help with the costs of long-term, chronic illness. As Chart 1 indicates, nursing home stays account for over 80% of the expenses incurred by older people who experience very high out-of-pocket costs for health care (over $2,000 per year). (For those with out-of-pocket expenditures of $500 or less each year, the big culprits are physician charges and drug costs.)

The need for long-term care leads almost inevitably to an unmanageable financial burden because the costs of care -- be it in an institution or in the home -- are often enormous. Chart 2 shows the mount that an individual would pay for a 12-month stay in a nursing home and for modest medical expenses during that year. At more than $20,000 each year, few families could survive such expenses without severe financial hardship. Medicare and private insurance combined pay only a minuscule proportion of nursing home costs (less than 3% in 1985). More than half of nursing home costs are paid out of the pockets of residents or their families. Most of the remaining costs are paid under Medicaid, a means-tested welfare program. To qualify for Medicaid, one must either be poor or reduced to poverty in the process of trying to pay for care.

Few people can afford the expense of an extended nursing home stay, so many eventually end up on Medicaid, but only after financial catastrophe has occurred. Fully one-half of Medicaid dollars for nursing home care is spent on behalf of persons who enter nursing homes as private paying residents. The process of "spending-down" one's income and depleting one's assets to qualify for Medicaid can occur very quickly. A 1985 study conducted for the House Aging Committee found that approximately 2/3 of single older persons and 1/3 of older couples in Massachusetts were impoverished after only 13 weeks in a nursing home.

As such statistics indicate, the impoverishment of a spouse in the community in order to finance the care of an institutionalized mate is one of the most serious problems facing older couples today. To be eligible for Medicaid, couples must often spend-down their combined income and assets, leaving one spouse -- usually the wife -- destitute. Many of the same women who are caught in the spend-down problem have spent years taking care of ill and disabled husbands at home.

Only a small percentage of long-term care is provided by institutions. The vast majority -- nearly 75% -- is provided in the community or home. Caregivers, who must often provide round-the-clock attention to disabled individuals, make both emotional and financial sacrifices to meet that need.

Brief periods of respite care could sustain the caregivers in this difficult situation and make it possible for them to continue to provide care in the home.

Personal care services of indefinite duration in the home are not covered at all by Medicare, and the amount and type of home care provided under Medicaid is extremely limited in most states. Even those who can afford to pay for home health and other in-home services face often insurmountable barriers in locating competent, trained personnel. As a result of both limited access to home care and the very high expense of nursing home care, many older persons live in fear of becoming a burden on their families, or being forced to enter a nursing home and spend their lifetime savings in order to pay for care.

For older Americans who have Medicare coverage, an acute care illness is less likely to result in a catastrophic burden than a long-term illness. But Medicare's coverage of acute care is by no means without significant gaps, gaps which if not supplemented by other forms of insurance, leave individuals vulnerable to devastating medical costs. Chart 2 shows that a Medicare beneficiary with two hospital stays would, on average, incur out-of-pocket expenses that would total nearly $3000 without private supplemental insurance and would even result in expenses over $1600 with an average insurance policy.

Medicare beneficiaries' liability for acute care medical costs consists of two components: (1) Medicare cost-sharing requirements (i.e., deductibles and coinsurance) for covered services, and (2) expenditures for non-covered medical services and goods. It is important to distinguish between these two categories of liability since most of the catastrophic "cap" plans that have been proposed permit the former (coinsurance and deductible amounts) to be counted toward the cap but exclude the latter (expenditures for non-covered services and goods). And the second category of liability is by no means insignificant; we estimate that, on average, for every $1.00 beneficiaries incur in coinsurance and deductibles, they spend an additional $.50 to $1.00 for non-covered services and goods.

A. Deductible and Coinsurance Liability

Under Medicare Part A, beneficiaries are required to pay a hospital deductible in each benefit period approximately equal to the cost of one day of hospital care ($520 in 1987). They are also responsible for coinsurance for days 61 through 90 equal to one-fourth of the hospital deductible. For each lifetime reserve day (days 91 through 150), beneficiaries are required to pay an amount equal to one-half the Part A deductible, or $260 per day in 1987. While there is no deductible for skilled nursing facility (SNF) services, Medicare beneficiaries this year will pay $65 per day to satisfy coinsurance requirements for days 21 through 100 in a SNF.

Approximately 23% of Medicare enrollees are admitted to a hospital at least once in a given year. But only about .5% of Medicare enrollees (158,000 in 1984) use more than 60 hospital days in a year, thereby triggering hospital coinsurance requirements.

In 1985, Medicare beneficiaries incurred $3.2 billion in Medicare hospital deductible and coinsurance liability. This amount represented an increase in such aggregate liability of more than 100% between 1980 and 1985. The largest portion of total Part A cost-sharing liability is attributable to the Part A hospital deductible.

Beneficiaries also share heavily in the cost of Medicare Part B services. Each beneficiary must meet a $75 annual Part B deductible, and is also responsible for 20% of the amount that Medicare deems "reasonable" for a particular Part B service. (In addition, beneficiaries whose doctors do not accept assignment are fully responsible for the amount their doctor charges above the Medicare-approved rate.)

Cost-sharing requirements under Medicare Part B impose a far greater financial burden on Medicare beneficiaries than do cost-sharing requirements under Part A. In 1986, Medicare beneficiaries incurred $5.7 billion dollars in Part B coinsurance liability and $1.7 billion dollars in Part B deductible liability. The most striking rate of increase in physician-related liability has occurred in coinsurance liability which in the aggregate has risen by 170% since 1980. Moreover, increases in Part B coinsurance expenditures have far outpaced increases in Social Security benefits.

Whereas only about one-fourth of Medicare beneficiaries will incur liability from the use of hospital services in a given year, 80% will incur liability from the use of physician services during the same period. Further only .5% of beneficiaries will trigger hospital coinsurance costs, but fully 60% of beneficiaries will incur coinsurance liability for physician services.

B. Medical Services Not Covered by Medicare

In addition to Medicare's cost-sharing requirements for covered services, beneficiaries also face significant out-of-pocket costs for those acute care medical services and goods which Medicare does not cover or which, in the case of certain services, are subject to Medicare's durational limits.

These acute care services include:

- Outpatient prescription drugs
- Balance billing by physicians on non-assigned claims
- Dental services/products
- Optical services/products
- Hearing care services/products
- Routine physician examinations, influenza shots, Pap smears.

Out-of-pocket expenditures for these non-covered acute care services can be staggering: almost $3 billion for balance billing by physicians; more than $2.3 billion for dental care and more than $1.4 billion for eye care.

The Medicare Catastrophic Protection Act of 1987 passed by the full House last month represents, in the view of the Association, a significant effort to expand Medicare's coverage in critical areas, although we are concerned about its failure to address the costs of long-term care and its cost to beneficiaries. The bill, H.R. 2941, offers the following benefits: it improves Medicare's coverage of hospital and physician costs; it expands Medicare-covered home health care services; expands Medicare's coverage of skilled nursing facility care; it provides respite care for the chronically ill elderly; it offers protections against spousal impoverishment; it requires Medicaid to pay Medicare premiums, deductibles, and coinsurance for Medicare enrollees whose incomes are at or below the poverty threshold; and last, but by no means least, it offers significant protections against the cost of outpatient prescription drugs.

The bill does not, however, deal adequately with the costs of long-term care, the single greatest source of catastrophic costs for older Americans. Additionally, it fails to address the potentially significant costs associated with an array of acute care services and goods not covered by Medicare. These include: charges by "non-assigned" physicians that exceed Medicare's allowable rates; costs associated with dental care, vision care, and hearing care; and physician examinations, flu shots, and Pap smears. Finally, under the provisions of the House bill, beneficiaries remain exposed to approximately $1800 each year in coinsurance and deductibles for non-drug-related Medicare-covered services. They are additionally responsible for a $500 annual drug deductible and 20% of the costs of outpatient drugs beyond the $500 deductible.

Legislation with similar benefits is soon to be debated in the Senate, although the Senate bill lacks several important benefits: at this point, it contains no outpatient prescription drug benefit; it lacks a provisions that would effectively protect low-income Medicare enrollees against the cost of Medicare premiums, coinsurance, and deductibles; it fails to provide adequate protections against spousal impoverishment.

Both the House-passed bill and similar legislation now being considered by the Senate would require Medicare enrollees to pay the entire cost of the benefits described above through new premiums. Both measures require all beneficiaries to pay an additional basic premium from $3 to $4 per month beginning in 1989.

Both bills also include an income-related supplemental premium. Under the House bill, the maximum supplemental premium ($580 in 1989) would be paid by individuals with total income of $19,200 or more. The maximum under the Senate bill ($844 in 1989) would be paid by those with total incomes of $55,000 or more. These new catastrophic premiums -- both the basic and income-related premiums -- are in addition to the premium all beneficiaries currently pay for Medicare Part B services. The current-law Part B premium will be $275 in 1989.

Although the Association supported passage of the House bill, we continue to have concerns about its financing provisions. We have consistently argued that the catastrophic package should be financed through a combination of premiums, inclusion of all state and local government employees under Medicare, and -- for Medicaid improvements -- an increase in the tobacco tax.

Throughout the history of the program, Medicare financing has not required enrollees to pay the full cost of the program. The House bill's financing provision marks the first time that enrollees are being asked to carry the entire cost of expanded Medicare benefits.. We recognize that the elderly must pay part of the cost of the catastrophic package, but not the total cost. We also recognize that the package must not increase the federal deficit.

The Association believes that the financing of catastrophic health care benefits should maintain the social insurance principles of Medicare. We are urging the Senate to adopt our recommendations -- a combination of premiums, inclusion of all state and local government employees under Medicare, and a tobacco tax -- for financing the package. We will also continue to urge Congress to develop a comprehensive and effective national policy on long-term care, including coverage of both nursing home and home-and- community based care.

II. MEDIGAP'S ROLE IN PROTECTING BENEFICIARIES AGAINST CATASTROPHIC COST

The gaps in Medicare's coverage, particularly its cost-sharing requirements, have led to the development of private supplemental insurance plans, so-called "Medigap" policies. About 70% of Medicare beneficiaries are covered by such plans. Since the enactment of the Baucus amendment in 1980, Medigap plans are required to cover: (1) hospital coinsurance; (2) 90% of Part A expenses after exhaustion of the lifetime reserve to a lifetime limit of 365 additional days; and (3) the 20% coinsurance on Medicare Part B services. Such plans are not required to cover either the hospital or physician service deductible, although most offer coverage of the former. Finally, the plans may impose their own deductible of up to $200 per year for Part B coverage.

In spite of the Baucus amendment, there is great variability in the depth and scope of coverage provided by Medigap plans. Medigap plans provide little or no coverage of prescription drugs, balance billing by physicians, dental services, and extended nursing home care. Moreover, the Baucus amendment does not apply to employment and labor organization-related group insurance, conversions from group plans to individual policies, and policies in effect before July 1, 1982. Finally, some plans may be very costly relative to the benefit returned to the insured.

It should be noted that supplemental coverage through a Medigap plan is positively correlated with income and education. Yet almost half of elderly people with less than $5000 per year in family income purchase Medigap plans (see chart 3). Even if the coverage selected is modest, the premium payments for such plans must constitute a terrible drain on already meager resources.

Let me at this point clarify the Association's position on the ability of the private insurance industry to protect older Americans from the inadequacies of Medicare's coverage. The Association offers its members a Medicare supplemental insurance plan that fills many of the existing gaps in Medicare coverage. We believe, however, that filling such gaps through the Medicare program is inherently the most efficient way to insure against acute care catastrophic costs. Accordingly, we welcome any meaningful improvements in the Medicare program that will reduce the need for supplemental insurance plans or make them unnecessary.

As indicated above, the Association has urged the passage of legislation that would protect beneficiaries against the costs of high-cost illness. But even assuming enactment of the catastrophic legislation, gaps in coverage will remain, and beneficiaries will undoubtedly seek and purchase supplemental insurance to protect themselves, to the extent possible, against remaining potential liability. It is thus appropriate that the current law governing the composition, marketing, and performance of Medigap policies be reviewed and that the effectiveness of existing standards be examined, to determine whether changes are needed.

In addition to specifying the minimum benefits cited above, the Baucus amendment established certain marketing and performance standards for Medigap policies. Included in the marketing standards are consumer disclosure requirements governing descriptions of benefits, exceptions, limitations, renewal provisions and the right of the purchaser to return the policy for a full refund within 10 days if it is sold by an agent or within 30 days if sold through a direct response (mail) solicitation. The law also contains criminal penalties for fraudulent sales practices, including the knowing sale of duplicative coverage.

The performance standard requires an actuarial demonstration that the policy can be expected to return a certain percentage of its premiums in benefits. This is known as a loss-ratio. For group policies the expected loss-ratio must be at least 75%. For individual policies (including all policies issued as a result of mass media advertising) the expected loss-ratio must be at least 60%. There is no current federal requirement that actual loss-ratio performance be evaluated or that any performance standard be met.

Last fall, the General Accounting Office issued a report assessing the implementation of the Baucus standards. The report concluded that the general objectives of Baucus were being met, in that most states had responded to the encouragement to regulate Medigap policies, by adopting programs at least as stringent as the federal standards.

However, the report noted that the actual loss-ratios of most policies examined by GAO were below the Baucus targets. A 60% loss-ratio was found to be the average of policies surveyed, not the minimum. GAO noted that the Baucus requirements do not require actual loss-ratios to meet the standards, only that the actuarially expected loss-ratios do so.

The GAO also reported that abusive sales practices continued although many states have begun monitoring advertising and sales practices and revoking agent licenses or issuing cease and desist orders against insurers.

AARP believes that the Baucus amendments have had a positive impact on the Medigap industry. We also believe there is justification for strengthening them. Our seven years experience with implementation of these standards has given us an ample record upon which we can judge their performance and recommend needed improvements.

A. Minimum Benefits for Medigap Policies

If catastrophic care legislation is enacted in its current form, it will restructure Medicare benefits in such a way that the current minimum benefits requirements for Medigap policies will be obsolete. We propose establishment of new minimum benefits standards along the following lines.

(1) Part A

The proposed changes to Medicare will leave very little Part A risk left to insure: one hospital deductible and a relatively small nursing home coinsurance for 7 to 10 days. All Medigap policies should cover the full nursing home coinsurance. The cost is not substantial, and consumers will expect their Medigap policies to cover this type of risk.

Medigap policies should be required to cover either all or none of the Part A hospital deductible. It may be wise for some consumers to self-insure this deductible, especially since Congress has limited its growth. Allowing a range of deductibles (i.e. $100, $250, etc.), however, will unnecessarily confuse consumers and reduce comparability of policies.

(2) Part B

All Medigap policies should cover the Part B coinsurance up to the new out-of-pocket cap, subject to a deductible equal to the Part B deductible (currently $75). The proposed changes to Medicare Part B reduce the high-end risk for Medigap insurers. Given those changes, there is no excuse for covering less than the $1000 cap. A front-end deductible is reasonable because it is simply dollar trading, or worse, to have first dollar coverage for physician expenses. Although a higher deductible may actually be a better insurance buy for many people, current experience with the $200 deductible indicates that neither regulators, consumers, nor on occasion insurers actually understand how it works.

(3) Other Medicare Benefits

In addition to the above standards for minimum benefits, some rules should be established if insurers supplement other Medicare benefits (i.e. additional nursing home days or home health days).

To assure that all benefits are easily understandable, insurers should be required to use the same definitions and eligibility criteria as Medicare, including those for covered facilities, conditions and levels of care. If Medigap policies provide benefits that are more generous than Medicare (i.e. transitional care, private duty nursing, coverage in non-Medicare approved facilities, etc.), the benefit should be described as an independent benefit and not as an addition to the benefit Medicare already pays. This should be explained in a manner that does not overstate the significance of any incremental benefit.

B. Loss-Ratios

Revisions to Medigap loss-ratios should be adopted, regardless of whether catastrophic legislation is enacted.

There are two problems related to the current loss-ratio standards: (1) the enforcement of existing standards is inadequate, and (2) the existing standard is too low.

Many insurers are not meeting the minimum 60% loss-ratio standard contained in federal and state law for individual and mass marketed Medigap policies. This problem can be addressed by stricter enforcement of existing standards by Insurance Commissioners. To ensure that all states more actively monitor loss-ratios for this coverage, the Baucus standards could be modified to require (1) that actual as well as expected loss-ratios be reviewed periodically and (2) that states have procedures for requiring insurers to lower premiums, give refunds, or increase benefits if the insurer does not meet the expected loss-ratio over a reasonable period of time.

Another method of motivating loss-ratio compliance would be to require insurers that do not meet the minimum loss-ratio standard over a reasonable period for their "developed business" to disclose that fact in their solicitation materials. New products should be exempt from this process until there is sufficient experience to make the loss-ratio data credible.

The second problem associated with Medigap loss-ratios is that the existing minimum loss-ratio for individual and mass marketed policies is too low. Insurers could write this coverage at higher loss-ratios, perhaps 70%, and still make a reasonable profit. Insurers should not be permitted to amass unreasonably high profits at the expense of the elderly. Indeed, the ability to make high profits on this line of business undoubtedly explains the prevalence of misleading and abusive sales practices in this market. To prevent unreasonably high profits and to remove some of the incentives for disreputable marketing and sales, the loss-ratio standard for individual and mass marketed Medigap policies should be increased. We recommend that the minimum standard be set at 70% unless the insurance industry can demonstrate that this standard would not permit a reasonable rate of return.

C. Marketing and Disclosure

(1) Lead Generation

A relatively new form of abusive marketing has developed in the Medigap market, often referred to as "cold lead advertising." In this type of operation, older persons are mailed material advising them that changes are being made to Medicare or to other programs, and offering to provide more information. This material often is official looking, with a Washington, D.C. return address. The names of those who respond and request additional information are sold to insurance agents or insurance companies, usually resulting in a visit to the home by an agent. In some cases, the lead generation is done by insurer subsidiaries. Rarely, if ever, do persons receive the information they believe they requested.

This type of marketing is deceptive, misleading and abusive. Not only does the original solicitation misrepresent its purpose, but the uncertainty and misapprehension raised by this initial material mayo help the agent pressure the person into a quick sale. Although virtually all states have laws that prohibit fraudulent and misleading advertising and solicitation, this practice persists in many places. Some states, such as Washington, have taken action to eliminate this type of solicitation.

To better protect beneficiaries nationwide, the Baucus legislation should be expanded both to prohibit many of the fraudulent practices that now exist and to require states to have effective enforcement mechanisms in place. As a bare minimum, insurers and insurance agents should be prohibited from using or soliciting from lists that they know were generated in a fraudulent or misrepresentative manner. With catastrophic legislation pending, this area needs immediate attention.

(2) Duplication and Replacement of Coverage

Other problems often seen in the Medigap marketplace are frequent replacement and duplication of coverage. Since agents receive a higher commission on new sales than on renewals, some agents try to convince persons who already have adequate coverage to replace their policy with a new one. Older persons also often are sold duplicative coverage by agents or through the mail.

The practices have serious costs. Persons who replace their coverage are faced often with new preexisting condition exclusion periods, waiting periods or underwriting restrictions. Purchasing two policies to cover the same risk is a wasteful and unnecessary use of money, and may seriously burden those with limited resources. Unfortunately, the fear of catastrophic health expenses and a misunderstanding of Medicare and Medigap coverage, cause some older persons to overinsure. While it may be impossible to eliminate these problems entirely, better education and reasonable disclosures and warnings should reduce the magnitude of these problems significantly.

Many insurers and agents do not warn potential customers that they do not need more than one Medigap policy. To better inform senior citizens of this fact, disclosure sections on duplication of coverage should be required on application forms and outlines of coverage. Since Medigap policies differ, the section should contain a list of the typical benefits in Medigap policies, with language that explains that a person generally does not need more than one Medicare supplement policy and that a person need not buy a policy for the purpose of covering any of the listed benefits if the person already has coverage for the benefit.

Another method of protecting against duplication of coverage is to require insurers to develop underwriting requirements which prohibit an individual from having more than one Medigap policy from that insurer.

Currently, individuals who are replacing one health insurance policy with another must receive a statement notifying them of their right to a "free look," their right to get advice from their present insurer or agent, and the fact that existing health conditions may not be immediately covered under the new policy. While this notice is useful, it could be improved. Insurers should be required to use notice forms which state specifically, in large type, if there will be any lapses in coverage or other restrictions under the new policy because of the replacement of coverage. The notice form should also disclose if an agent may get a greater commission for replacing coverage than for renewing existing coverage. This hopefully will caution the applicant to closely question if the new coverage would better fit his or her needs. Finally, the notice form should contain the number of the consumer affairs department of the state Insurance Department so that applicants can call with questions or concerns if they are confused by an agent's or insurer's explanation.

(3) Free Look

All Medigap policies are required by Baucus to have a "free look" period, a time after issuance of a policy within which a person may cancel and return it for a full refund. This time period currently is 10 days for policies sold by agents and 30 days for policies sold through direct mail solicitation or mass media advertising. In light of experience with agent abuses, we believe 10 days is too short a time for an individual to rethink a decisions that may have been made under pressure and to take the appropriate action to cancel. The "free look" period should be extended to 30 days for all sales.

III. NEED FOR MORE PHYSICIANS TRAINED IN GERIATRIC MEDICINE

There is little doubt that efforts to improve Medicare's coverage for both acute and chronic illnesses will be undermined unless there are adequate numbers of appropriately trained health care providers. The physical and mental health needs of older adults often differ from those of younger persons, necessitating specialized training in geriatric medicine. Yet, according to a recent report by the Institute of Medicine (IOM), the numbers of older persons who will need specialized care by the year 2000 will far outstrip the numbers of physicians trained in providing that care.

One major reason for the shortage of geriatricians is the lack of adequate training and research opportunities at all levels of medical education. Even though we are beginning to see an oversupply of physicians in some specialties, the shortage of geriatricians will continue for years to come because so few students are currently receiving training. Not only are training opportunities limited, but only a small percentage of medical students choose to take those elective courses in geriatrics which are available, and very few residents choose geriatric rotations.

The reasons that so few medical students have been attracted to the field of geriatric medicine are many. The medical problems of elderly persons, particularly chronic illnesses, are often viewed as unexciting and untreatable. Research opportunities in geriatrics tend to be underfunded and, until recently, there has not been a well-defined career track in geriatric clinical practice. Finally, compared with many other specialties, there are few economic incentives to practice in the field because good geriatric care often does not entail the use of high-cost technologies or complex procedures.

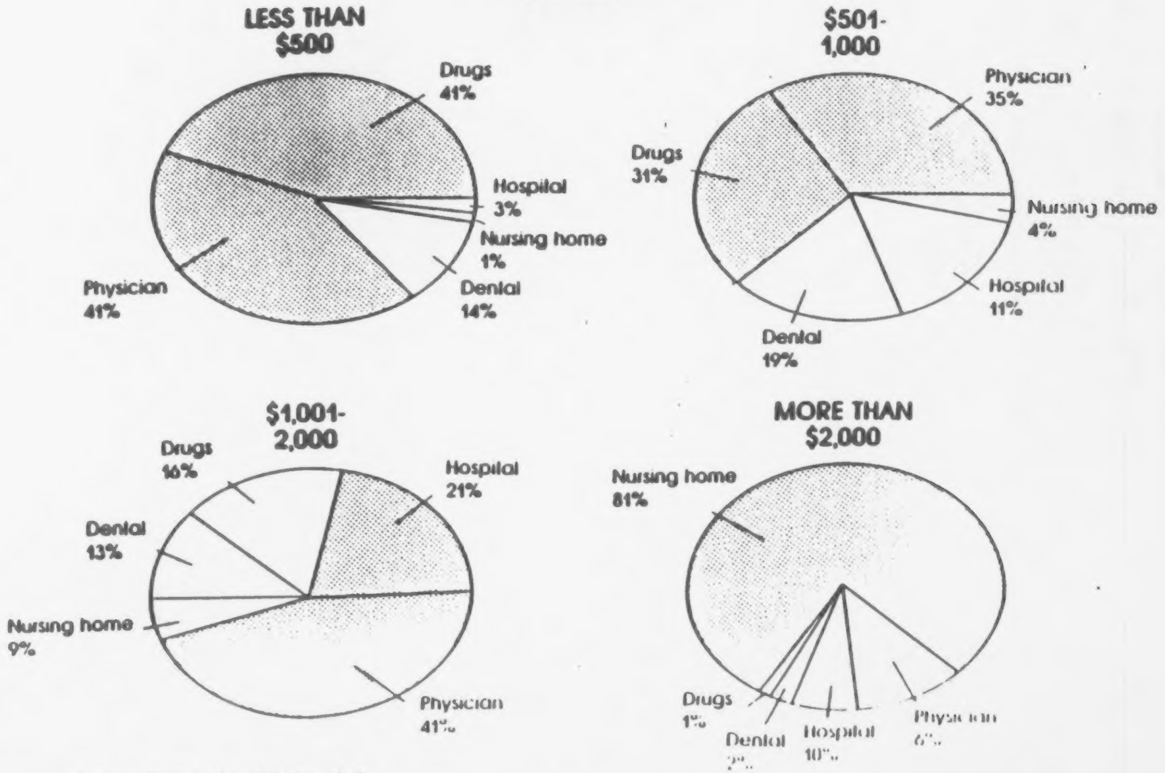
These factors, coupled with the slow growth in training opportunities, have resulted in a serious undersupply of physicians able to care for our rapidly growing older population. A crucial first step in addressing this problem will be to train sufficient numbers of academic leaders in geriatrics. According to the IOM, our nation will conservatively need 2,100 academic geriatricians if we are to establish high quality geriatric training programs in all U.S. medical schools by the end of the century. To reach this goal, we will need to double the current yearly output of 100 graduates in geriatrics.

The Association wishes to commend Senator Sasser, along with Senators Durenberger, Kerry, Heinz and Glenn for introducing legislation which would promote the development of academic leaders in geriatrics through the establishment of centers of excellence in geriatric research and training. In addition, AARP believes that our country should provide more geriatric training opportunities for nurse practitioners, physician assistants, and other health care personnel.

Thank you.

CHART 1

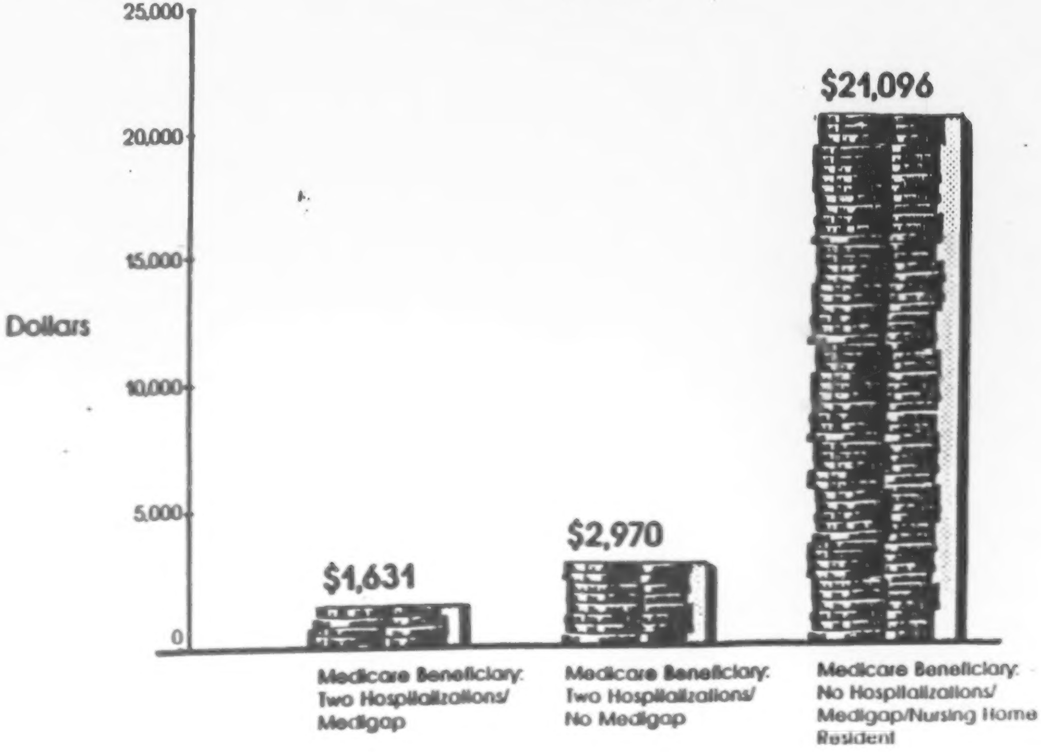
OUT-OF-POCKET COSTS BY TYPE OF SERVICE (1980)



[illegible]

CHART 2

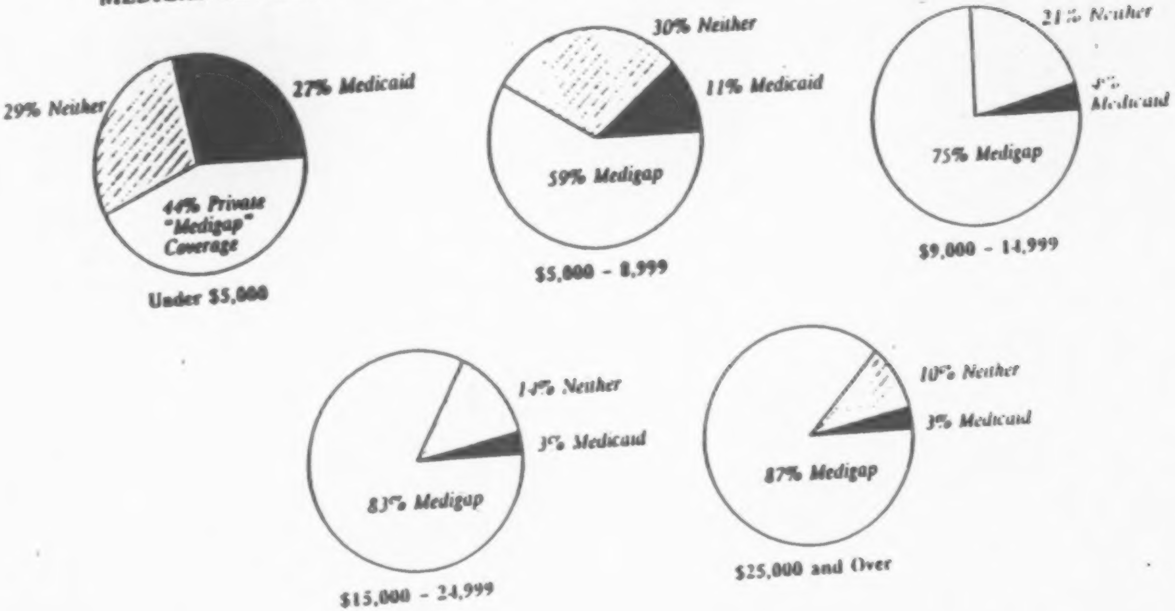
ANNUAL OUT-OF-POCKET MEDICAL EXPENSES FOR THREE MEDICARE BENEFICIARIES (1987)



[illegible]

CHART 3

MEDIGAP COVERAGE FOR THE ELDERLY POPULATION BY FAMILY INCOME, 1986



Source: Congressional Budget Office

LINDA O'NEAL
STAFF ATTORNEY/LEGISLATIVE ADVOCATE
TENNESSEE ASSOCIATION OF LEGAL SERVICES

GOOD MORNING! Senator Sasser, I am Linda O'Neal, Staff Attorney/Legislative Advocate for Tennessee Association of Legal Services (TALS), which is the state support office for the eight (8) legal services projects in Tennessee. As you know, legal services provides representation for low income people on a wide range of civil legal issues. Health care is one of those issues. As the state support office, TALS provides training, technical assistance, task force coordination, and information dissemination services for the local legal services projects. We also serve in a co-counsel role with local legal services attorneys in providing administrative and legislative advocacy on behalf of eligible clients and we provide information and assistance in response to legislative and administrative requests.

I appreciate the opportunity to provide testimony today concerning health care needs of the elderly, particularly the low income elderly. This is certainly an exciting time to deal with this issue because of the significant legislation that is currently pending before the U.S. Congress, including key bills that you have introduced, and the distinct possiblity of important improvements in Medicare and related financing mechanisms for health care for the elderly.

When the Medicare program was established in 1965, it was widely acclaimed that it would dispel the concerns of the elderly regarding their ability to access and pay for health care.

However, that promise has never been fulfilled and in fact today access and ability to pay for health care are paramount concerns for the nation's growing elderly population. The current deliberations by Congress once again give hope that the Medicare program will be expanded to fulfill that initial promise.

Today I would like to discuss the five (5) issues that I believe must be addressed in Medicare expansion in order to provide meaningful improvements in benefits for the elderly:

1. Prescription drug coverage;
2. Reductions in deductibles and co-payments;
3. Long-term care;
4. Spousal impoverishment; and
5. Financing Medicare expansion.

If time permits, I will also address important issues related to "Medigap" or Medicare supplement insurance. In any case, comments on this topic are included in my written testimony.

PRESCRIPTION DRUG COVERAGE

Many older persons have up to ten or twelve prescriptions each month. It is not unusual for the elderly to have monthly drug bills of $100 to $200. On fixed incomes, and without assistance from Medicare or Medicaid, thousands of elderly Tennesseans are forced each month to choose whether to purchase the medication for their heart condition or the medication for their digestive difficulties, or other vitally important prescriptions that they need but simply cannot afford. In addition to choosing among their prescriptions, they may also have to choose between paying for necessary medications and paying for other basic necessities - food, utilities, etc.

It is essential that Medicare begin to provide at least some assistance in covering the cost of prescription drugs which must be taken on an outpatient basis. The failure to provide such coverage is often penny-wise and pound-foolish. When economic conditions force elderly Tennesseans to go without preventive and stabilization medications, they precipitate more serious illness that results in greater costs of hospitalization and/or nursing home care.

REDUCTIONS IN DEDUCTIBLES AND CO-PAYMENTS

Current high deductibles and co-payments create significant economic hardships for the elderly, particularly the low income elderly. While hospitals are mandated to serve Medicare patients even if they cannot pay deposits which are required to cover deductibles, many elderly persons are reluctant to seek needed hospitalization because of justifiable fears of the humiliation they may face. Consequently, necessary medical care is delayed until it is either much more costly or too late altogether.

The average Social Security pension of an elderly widow is $433 per month, and the average Social security pension of a disabled worker is $467. If the pensioner requires hospitalization, the inpatient hospital deductible alone, currently $520, exceeds his/her total income for a month. Thus, the average social security pension is obviously inadequate to pay deductibles and co-payments for hospital and medical services, not to mention basic necessities and expensive prescriptions which may be required as an outpatient.

Current proposals for increasing Medicare coverage to eliminate multiple Part A hospital deductibles in a single year will benefit relatively few Medicare recipients, but are nonetheless important improvements. Proposals to expand Part B or add new Part C coverage for medical services are extremely important. It is particularly critical that the expansions include provisions for preventive care. Mental health benefits have historically been extremely inadequate and should also be improved.

LONG TERM CARE

The lifetime risk for placement in a nursing home is 20% and at any one time 4% of the elderly are in a nursing home. The national average length of stay in a nursing home is 456 days, while the average length of stay in Tennessee is 366 days. More than half of all nursing home patients are there for less than three (3) months and 40% for less than one (1) month. While these statistics clearly indicate that the majority of the elderly either will not be in a nursing home at all, or will not have an extended stay in a nursing home, the greatest fear of elderly Americans is winding up in a nursing home - and having inadequate resources to pay for such care.

There must be adequate insurance mechanisms to provide coverage for long term care. While the private sector is currently beginning to provide such coverage, I would contend that Medicare should provide such coverage, and commend you, Senator Sasser for your proposal that it do so. Long term care coverage is essential for Medicare to fulfill its promise of alleviating the plight of ruinous health care costs for the elderly. Provisions for long term care coverage through Medicare would reduce or eliminate the possibility of exploitation of the elderly by unscrupulous long term care insurance agents, or the financial failures of insurance companies in an era of corporate mergers, takeovers, and raiding. It would also provide a better economy of scale to maximize the use of health care dollars and reduce the cost for everyone as it spreads the risk of nursing home placement.

SPOUSAL IMPOVERISHMENT

Closely related to the need for adequate coverage for long term care is the issue of spousal impoverishment. The cost of health care in the event of a catastrophic illness or any condition that requires long term nursing home care is astronomical. Countless times the media have presented moving portrayals of the devastating plight of these people. These costs frequently leave the surviving or community spouse totally impoverished. At the present time in Tennessee, a nursing home Medicaid recipient's homemaker spouse who has no Social Security or other pension benefits of her own is frequently left with only $150 per month for her total living expenses. Even assuming she lives in a mortgage-free family home, this amount is obviously inadequate for food and utilities, much less health care needs or additional Medicare premiums.

While coverage for long term care is the ultimate goal, Congress should take immediate steps to minimize the adverse impact on the spouse by providing for the retention of sufficient income and assets. The provisions of HR 2470, which has already passed the House, are a significant step in the right direction.

FINANCING

Congress must establish a financing mechanism for expansion of Medicare that will provide sufficient funds for the expanded services. At the same time, that financing mechanism must not present an undue burden on low income elderly Americans. Information available on the mechanism provided by HR 2470 appears to indicate that it may be a reasonable approach to financing Medicare expansion, as may your proposal in S. 454. However it is accomplished, it is critical that increases in premiums be related to ability to pay. Currently many elderly persons are virtually unable to pay the Part B premium. Payment of additional premiums, even for significantly increased coverage is simply not economically feasible for them.

It is strongly recommended that Congress mandate a state "Medicaid buy-in" for all elderly and disabled who are under the federal poverty line. Such a provision should require the states to pay the Part B premium and any additional premiums necessary to finance Medicare expansion, as well as require Medicaid coverage for deductibles and co-payments. Cost savings from Medicare expansion should minimize the adverse economic impact of such a Medicaid buy-in requirement on the states. Such a provision is included in HR 2470.

While I recognize that some senior citizens groups oppose a Medicare expansion financing mechanism that requires increased premiums based on ability to pay, it appears to me that such a mechanism is the most appropriate way to finance Medicare expansion. While there is significant poverty amoung the elderly, the prevalence of poverty is even greater among women and children. We cannot continue to mortgage our future through huge budget deficits, and social programs that have been significantly reduced throughout this decade simply cannot withstand further reductions to pay for Medicare expansions out of general appropriations. Even though the elderly who have resources would have increased costs with an increased Medicare premium, such a premium is still likely to be significantly less than current medical insurance premiums for younger Americans which are purchased either individually or by their employer. Increased Medicare coverage would offset some of the increased premium cost. Additionally, expansions of Medicare should result in reduced costs in remaining Medigap premiums since such insurance would be covering lower deductibles and co-payments.

MEDIGAP POLICIES

While some Medigap policies provide excellent insurance coverage for the elderly, many do not. The language in many of the policies is extremely complex and confusing. It is difficult for anyone, much less an elderly person experiencing extreme stress from fear of financial disaster caused by medical bills, to really understand what individual policies cover. While the majority of Medigap policies cover deductibles for multiple hospitalizations within a year, some do not. Most do not provide any coverage for outpatient prescription drugs, which is a key reason that Medicare expansion in this area is so critical.

The Part B medical coverage of different Medigap insurance policies vary significantly. It is often extremely difficult to determine what a specific policy does cover. One reason for this is because many policies present their provisions in terms of percentages of Medicare coverage. Since Medicare itself only pays a percentage of such costs, prospective buyers are dealing with calculating percentages of percentages to even try to determine potential benefits. Another difficulty arises from the fact that definitions may also vary from policy to policy.

A particular problem with Medigap policies, and health care costs for the elderly in general, arises out of confusion over provisions for doctor bills, supplemental Part B coverage. Doctor bills are either "assigned" or "unassigned". When a doctor accepts a Medicare assignment, Medicare pays 80% of an established fee and the doctor can only charge the patient for the remaining 20% of the scheduled fee. If a doctor does not accept assignment, which the majority in Tennessee do not, then the patient may be liable for significant additional charges beyond the Medicare established fee. This causes considerable difficulty financially for the low income elderly, and may make it virtually impossible for them to locate a doctor who will treat them, particularly a specialist. The issue of assignment also contributes to the confusion regarding the exact benefits that are available under Medigap policies.

Additionally, buyers often mistakenly assume that their Medigap policy will assist with health care needs, particularly long term care, when they do not. This is particularly a problem because most people do not understand the difference in skilled nursing care, which currently is covered to a limited extent by Medicare and many Medigap policies, and intermediate care, which is the primary type of nursing home care provided in this country. Only special long term care policies which have recently become available provide payment for services in intermediate care facilities, but few understand these technicalities.

Other problems with some Medigap policies relate to their renewability or the lack thereof. When policies are not renewed or cancelled on relatively short notice, former policy holders may find themselves without coverage at a time when a health emergency arises. Recently 6,700 elderly Tennesseans had their Medigap policies cancelled simultaneously. Additionally, most Medigap policies do not provide any coverage for disabled Social Security recipients who are under age 65. Expansion of Medicare is the only option for increased coverage for these people.

In conclusion, the area of Medigap insurance is fraught with problems and frustrations for the elderly. It is certainly posible for an elderly person to spend excessive amounts of very limited income for Medigap insurance that provides them relatively little benefit. In fact, it happens all the time. Expansions of Medicare are the best and most economical means of providing more adequate health coverage for all elderly Americans.

CONCLUSION

In closing, Senator Sasser, I would like to commend you for the leadership and commitment you have demonstrated in the area of improved health care for the elderly. I encourage you to continue that effort, through sponsoring or supporting legislation for Medicare improvements. Such legislation should included the following:

- Prescription drug coverage;
- Provisions for preventive care;
- Reductions in deductibles and co-payments;
- Long term care provisions, including intermediate care;
- Protections against spousal impoverishment; and
- Financing mechanisms with mandatory Medicaid buy-in and premium increases based on ability to pay.

Statement of Gene Holcomb
of
Blue Cross and Blue Shield of Memphis
on
Coverage of the Elderly's Catastrophic Health Care Expenses & Related Matters

Introduction

I am Gene Holcomb, Chief Financial Officer for Blue Cross and Blue Shield of Memphis and President of Southern Health Plan, Inc., Tennessee's largest Health Maintenance Organization. I have had experience with the Medicare program since its inception. Our organizations currently provide Medigap coverage to an estimated 22% of Memphis beneficiaries and serve as Part A Intermediary for Medicare.

We applaud your concern for protecting the elderly from financially catastrophic health costs while desiring to ensure that each individual has ready access to quality health care.

Expanding Medicare to Include Medicare Catastrophic Coverage

1. The private Medigap market has, in general, adequately protected the majority of beneficiaries who have elected to purchase (or who can afford to purchase) such supplemental coverage. However, the vast majority of Medigap policies essentially only pay the Medicare coinsurance and deductible amounts plus extend the lifetime maximum of covered days (usually by 365) and pay 20% of physicians' approved charges, home health and other related items. Most often, no coverage is afforded for services not of a nature and type covered by Medicare.

2. The major need in the acute-care catastrophic coverage arena is meeting the needs of the beneficiaries without private supplemental coverage because they either can't afford it or don't choose to buy it.

3. The most prevalent expense incurred by beneficiaries which is not usually catastrophic in nature is the difference between Medicare approved physician charges and the physician's actual charge.

4. The single greatest overall financial risk to the elderly is -- long-term (non-acute) care. We support addressing that risk -- but hope a plan could be devised to, in some manner, utilize the private sector

in partnership with government.

5. We oppose taxing Medicare in any manner to fund new benefits. Additionally, any funding mechanism should not disadvantage the low.income beneficiary.

6. The effect of Medicare cost shifting to the private sector is real and is being funded by corporate America and the American citizens who pay for insurance coverage. We oppose any further restrictions or cut-backs which could result in additional cost shifting.

7. We believe that expanding Medicare to include outpatient prescription drugs will be unduly expensive and promote excessive utilization without significantly increasing the quality of care. Although prescription drugs are a significant out-of-pocket expense to many beneficiaries, that cost should not be an unreasonable burden except to the lower income individuals. A program of assistance to these specific individuals might prove more cost effective overall.

8. We believe that the current restrictions on inpatient and outpatient mental health benefits under Medicare should be lessened or removed -- but only with special emphasis on utilization review programs to prevent abuse and overutilization in this area. Currently

Medicare limits mental health benefits to 190 lifetime inpatient days and outpatient expenses to $250 per year with 50% copayments.

Although these maximums affect relatively few beneficiaries, at least 10,000 nationally have exhausted their inpatient benefits.

9. There is periodic discussion about misleading advertising and marketing practices in the commercial Medigap market. Such practices are abhorent and usually illegal.

The National Association of Insurance Commissioners (NAIC) has already released an exposure draft of new Model Advertising and Marketing Regulations for Medigap and is developing a revised Minimum Medicare Supplement Standards Model Regulation. We support the work of the NAIC. Most states usually ultimately adopt the model NAIC regulations or embrace their intent in other state regulations.

Summary

In summary, we believe that private Medigap policies with appropriate regulation adequately serve most beneficiaries. We believe federal emphasis should primarily concentrate on the following:

(a) Encouraging beneficiaries who can afford Medigap policies to acquire them.

(b) Providing a funding vehicle to beneficiaries who cannot afford Medigap policies.

(c) Considering the expansion of Medicaid to further ensure access of quality health care to all Americans without being an undue burden on other areas of the health care delivery and financing system or on local governments.

(d) Exploring methodologies to provide long-term care preferably through a partnership between government and private industry.

(e) Expanding mental health coverage under Medicare accompanied by stringent review procedures.

(f) Avoiding further cost shifting from Medicare and Medicaid to the private sector.

Thank you for the opportunity to express our views.

Training Health Professionals with Expertise in Geriatric Medicine

By: William B. Applegate, MD, MPH; Professor of Preventive Medicine and Medicine; Chief of the Division of Geriatric Medicine, University of Tennessee, Memphis

We are all aware that the population of the United States is aging. Currently about 12% of the U.S. population is over the age of 65 years and by the year 2010 over 17% of the population will be over 65 years of age. Among elderly persons in our society, it is the oldest old, those over 85 years of age, who are currently enjoying the greatest increase in further life expectancy. In fact, the oldest old have recently shown the most dramatic increases in life expectancy of any age group in our population. Although it is projected that future cohorts of elderly people will be even healthier and somewhat less frail than our current elderly citizens, it will continue to be true that rates of disease and disability will increase with age. Currently over 80% of persons over age 75 have at least one chronic disease and at least two thirds have some limitation in their ability to perform activities of daily life.

These demographic shifts will have a profound impact on the American health care system. Currently about 26-28% of American total health care expenditures go for health care or long term care for the elderly, but by the year 2010, it is estimated that 46% of national health care expenditures will be consumed by care for the elderly. To further illustrate this issue, it is estimated that by the year 2000, health care expenditures for the elderly will be 40% higher than they were in 1980. Short-stay hospital days for the elderly will remain level or decrease for a short period of time but will begin rising again by the end of the century. Physician visits by the elderly will increase by at least 40% by the year 2000 and this could be an underestimate because of our pending surplus of newly trained physicians. The number of nursing home beds in this country already is greater than the number of acute care hospital beds and it is estimated that, by the turn of the century, the number of nursing home residents will increase by 67%. Simply substituting in-home care for nursing home care will not serve as a mechanism for reducing health care costs because it is estimated currently that for every frail or mentally impaired elderly person who enters a nursing home, there are three persons still residing in the community who are equally impaired and who could legitimately utilize any new at home long term care support services. In fact, the number of frail, homebound elderly persons is expected to increase 100% over 1980 levels by the year 2010.

Care of the growing numbers of old-old persons in our society is an intelectually and emotionally demanding task. Many elderly persons have several medical problems and management of these problems requires the ability to both balance the multiple medical problems which exist but also to sensitively integrate management of an array of social, family, and emotional issues which may be involved. Unfortunately, modern medical training with its excessive focus on disease-oriented high technology care often does not prepare its new graduates well in managing the complex nuances of care for the elderly. Further, modern medical education all but ignores many of the specific health problems that are extremely prevalent and cause great suffering among the elderly. Examples include the management of the dementias, such as Alzheimer's Disease, depression, overuse of multiple prescription medications, urinary incontinence, stroke, Parkinson's Disease, gait disorders, falls, and osteoporosis. The disease-oriented focus of modern American medicine does not allow enough focus on issues of health promotion. Therefore, most current graduates of health profession schools know little of the growing body of evidence that many of the changes we formerly attributed to aging are now known to be directly attributable to disuse or to an unhealthy lifestyle. Neither current health care graduates nor professionals already in the community are aware or prepared to integrate into their practices some of the new approaches being devised for assessment and rehabilitation of frail high-risk elderly persons. For instance, a recent study from UCLA shows that assessment and rehabilitation of high risk elderly persons who have been debilitated by an acute illness will actually prevent the need to be placed in a nursing home and actually causes a decrease in mortality and morbidity. This type of assessment and rehabilitation can only be accomplished by professionals who have been adequately trained in the complexities and nuances of care of high-risk elderly patients. Further, such care requires that the health professionals involved be capable of interacting effectively with a multidisciplinary health care team, another skill rarely addressed by current health professional education.

To address the burgeoning and complex health care needs of the elderly, at least two major issues must be addressed. First, their must be a nationally driven effort to upgrade the quantity and qualtiy of health care professionals needed to provide care to the elderly. Second, patterns of organization and reimbursement of health care services to the elderly must be substantially revised to provide a more rationally structured system of care with adequate resources to meet these needs.

To upgrade the quality and quantity of health professionals needed to help care for the elderly, the first step is to upgrade the capacity of our medical and other health science schools to adequately train students in this area. In order to accomplish this goal, most schools will have to have a critical mass of faculty who devote most of their time to care and research on the elderly. Unfortunately, at this time there are no more than a few hundred full-time faculty in geriatric medicine in the nation's medical schools. Faculty who provide high-quality care to the elderly are neede both as role-models to attract young students to the field and also to demonstrate that high-quality care can have substantial impact on the health and well-being of the elderly. Research is needed in part because care of the elderly is one of the areas of medicine which has received the least attention and funding to date, so that the body of knowledge about how to care for the special problems of the elderly has not grown as fast as have the needs of the elderly in our society. In addition, teaching about the care of the elderly is not enough to insure the growth and development of the field. Academic centers must be capable of integrating both education and research in order to produce the academic leaders and role models who will both advance our knowledge about how to care for the elderly as well as interest new students in the field.

A recent Institute of Medicine report has concluded that we will have to double our output of physicians specifically trained in geriatric medicine if we are to adequately meet the Institue's conservative goal of 2,100 geritricians trained by the year 2000. The American Geriatrics Society has recommended that each medical school in this country have a critical mass of at least five faculty members in geriatrics by the year 2000. In order to accomplish this modest goal, most of the graduates required by the Institute of Medicine's report would have to pursue academic medicine as a career. Under usual circumstances, any medical discipline finds that at least 50% of its graduates leave academic life for some form of private practice. In fact, there is already substantial competition for the hiring of new graduates between academic centers, hospital systems, and other large practice organizations. Neither the Institute of Medicine nor the American Geriatrics Society expect that geriatrics will become a heavily practice-oriented specialty. The emphasis in both these reports is on training enough academic leaders to assure that knowledge regarding care for the elderly continues to grow and is disseminated to both students in training as well as persons already in practice. Therefore to meet even our modest academic needs in geriatric medicine, the country will have to invest more resources in training programs for geriatricians. Obtaining the funds to do this should not be too difficult since excess dollars are still being contributed to training programs which train physicians in specialty areas where a surplus already exists.

I am Chief of the Division of Geriatric Medicine at the University of Tennessee. Our Division currently has five full-time MD faculty, two full-time PhD faculty, and three fellows. We provide a broad range of educational opportunities in service settings or models of care for the elderly and have and substantial number of funded research projects which are on-going. Although we have nearly achieved the critical mass to really be classified as one of the more sophisticated programs in the training of geriatricians, a number of problems remain. First, funding for fellowship positions to train the future academicians we desparately need is always precarious and we have had to struggle constantly to maintain the continuity and integrity of our fellowship program. Our University hospital directly supports the salaries for fellows in many high-technology specialties and subspecialties, but has never supported a single geriatric fellow position (despite the fact the Medicare is a major source of third-party reimbursement). Fortunately the Veterans Administration Hospital has been generous in supporting some fellowship positions. Also, maintaining core program support for faculty and staff requires enormous effort(but we have been reasonably successful). Some core support for key staff and faculty would give our program greater stability and continuity and allow us to focus more on creating new advances in the field of geriatric medicine.

I am very supportive of the new legislation which is being proposed to establish centers of excellence to train tomorrow's academic leaders in geriatric medicine. However, I think the proposed legislation to develop 5-10 geriatric centers of excellence has one specific weakness. I agree with the center of excellence concept but wonder if most of the centers which could potentially be funded under this mechanism might be already so well established that the incremental impact of the funding would not be as great as if the resources had been spread over a somewhat larger pool. Specifically, I recommend that part of the funds under this mechanism be allotted as initial development grants to a number of centers which might well have the capacity to become a center of excellence but would need some initial development money to reach such a stage. Some centers could choose to compete for a limited number of grants for fully developed centers of excellence while other centers could compete for shorter term development money with the understanding that there would be future competition for additional centers.

Earlier I stated that changes in the organization and financing of health care would also need to undergo revisions if we are to adequately address the complex problems facing us in the care of the elderly. The first observation I have in this regard is that the history of Medicare indicates that it has acted as a stimulus to both price inflation and the provision of excessive amounts of high-technology care. It is disturbing to realize that the elderly currently pay as much out of pocket for health care services as they did in 1964 before Medicare was enacted. This is not to say that Medicare has not been a needed and valuable program which has helped provide needed medical care to millions of elderly Americans. However, massive government third party reimbursement into a fee-for-service payment system is inherently inflationary, especially when physicians are paid according to usual and customary fees and hospitals have historically been reimbursed on a cost plus system. Medicare has been designed in such a way that it pays very well for in-hospital care and high technology care, but does not adequately address long-term care. Long term care has been left to the means-tested, state based Medicaid program. The fact that these two systems are separate negates any potential that bloated acute hospital revenues could in part be transferred to long term care. The addition of catastrophic health care on top of already bloated national expoenditures for acute hospital care does not really address the most pressing issue in health care of the elderly. The most pressing issue in health care of the elderly is not catastrophic coverage (which would benefit a relatively small fraction of the elderly population) but rather a system of reimbursement that places more emphasis on low-technology long term care (in home as well as nursing homes). In order to achieve a more rational system of reimbursement for care for the elderly the following components of a reimbursement system are needed: Capitation payment for all health care for the elderly (co-payments and deductibles would still be necessary), radical restructuring of fee and reimbusement shedules for both physician and hospital charges, national integration of payment for acute care and long term care into one reimbursement system, and distribution of resources for frail and high risk elderly on the basis of a case management system.

PREPARED STATEMENT OF RUFUS WILLIAMSON

Mr. Chairman, I am Rufus Williamson, Vice President of Blue Cross and Blue Shield of Tennessee. Blue Cross and Blue Shield of Tennessee based in Chattanooga is one of two Blue Cross plans located in Tennessee. We service 90 of the 95 counties in the state and cover 1.2 million Tennesseans including 175,000 Medicare supplement subscribers.

Status of Tennesseans

Although more than two-thirds of Tennesseans with Medicare including our subscribers have protection against catastrophic loss from hospital and medical expenses, many others do not have protection and consider themselves in financial jeopardy should they have a major illness or injury. For those without insurance protection or Medicaid coverage there is a real need for assistance in preventing the loss of financial security due to unexpected medical expenses.

Need For Catastrophic Coverage

There is no doubt that the Medicare program as presently configured does not provide comprehensive protection against high side costs resulting from major acute and some chronic illnesses. Even though the assignment rate for medical claims in Tennessee is now up to 70%, the other 30% is unassigned and the Medicare beneficiary is responsible for the 20% not covered by Medicare of the approved charges plus the balance above approved charges which can be substantial on major illnesses and injuries.

On the hospital insurance or Part A side of Medicare, multiple hospital deductibles of $520 for confinements at least 60 days apart and the limit of 150 hospital days and 100 skilled nursing home days have placed some beneficiaries at risk financially. Therefore, the need is clear for more comprehensive health care protection for the elderly.

Medigap Insurance

The private Medigap insurance plans offered by Blue Cross and others are being used by Medicare beneficiaries to protect against excessive out-of-pocket costs for acute hospital and physician care. According to the Congressional Budget office, about 72% of the elderly supplement Medicare with private coverage. About half of the supplemental coverage is provided on a group basis through the retirees former employer and about half is purchased individually. Most Medigap policies do not provide coverage for long term care.

There is a wide variety on the market of both group and individual supplemental policies with substantial variations in cost. The supplemental policies offered by Blue Cross and Blue Shield of Tennessee are currently paying out more than 95% of the amount paid by subscribers for the coverage excluding overhead. While some policies provide greater or lesser coverage than others, the protection against major financial loss is generally included in policies offered by well known companies.

To protect the elderly against low value insurance, forty six states including Tennessee have adopted requirements that meet or exceed the Baucus Amendment specifications for certified medigap policies. These policies provide at least a minimum set of benefits and pay out more than 60% of the income for benefits. According to the GAO, the Blue Cross plans in the various states traditionally average above a 90% pay out compared to a much lower pay out for commercial insurance companies.

Specific Needs

The problem that needs a solution is therefore not primarily for those with insurance coverage or those with Medicaid coverage but the 18-20 % with no coverage at all except Medicare.

The problem is primarily one of affordability for those with no coverage. For long term care, the problem is both affordability and availability.

To solve these problems, the Congress needs to help maximize the existing private sector solutions and find an effective method for providing coverage for the low income elderly. Use of general revenue funds and sources of revenue to prevent deficit spending will be the likely approach to be most acceptable.

For long term care, the solution is to encourage through education the early planning for this type of expense. Coverage purchased through private sources at an early age can be quite affordable compared to the high rates for some one needing the services in the immediate future. Since purchase through private sources is not a viable solution for persons with low income, an expansion of Medicaid would be the most practical approach. In this way, addressing the needs of the impoverished spouse in the community can also be addressed.

Suggested Financing

Finally, as Congress and the Senate in particular addresses the issue of affordability or ability to pay, related to catastrophic costs, we suggest you consider:

A) An income related premium set to finance the cost of catastrophic benefits only added to the tax liability of beneficiaries who must file tax returns. For example, those required to pay taxes at 15% could pay one amount, say $100 and those in the 28% bracket a larger amount ($200-$300) or

B) Setting the benefit level (out-of-pocket caps) based on income. For example, setting the cap for out-of-pocket $2,000 for most beneficiaries but a higher amount for higher income beneficiaries. The premium charged the beneficiaries could be a single affordable rate for all added to the Part B monthly premium to provide for catastrophic coverage.

Future Costs

To reduce escalation of medigap premiums in the future, it is important to limit the escalation of deductibles and out-of-pocket caps.

June 1987 #8702

Catastrophic Health Care Costs for Older Americans:

The Issue and Its Implications for Policy Development

by

Theresa Varner

The Public Policy Institute was formed in 1985 as part of the Division of Legislation, Research and Public Policy of the American Association of Retired Persons. One of the missions of the Institute is to foster research and analysis on public policy issues of interest to older Americans. This paper represents part of that effort.

The views expressed herein are for information, debate and discussion, and do not necessarily represent formal policies of the Association.

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I. INTRODUCTION

The catastrophic illness issue has captured the interest of the Reagan Administration, the Congress, and the American public as have few other health care issues in recent memory. While concerns about high cost illness are certainly not new, momentum on the issue has gathered dramatically since President Reagan identified it as one of the nation's most pressing public policy problems in his 1986 State of the Union address. This interest has served to lay bare the inadequacies of Medicare's acute care coverage of older and disabled Americans, as well as the intolerable costs associated with long-term care that can threaten the financial security of young and old alike.

Given significant attention to the problem of catastrophic illness by the news media and commitment to its remediation by both the Senate and the House of Representatives, some level of action on catastrophic illness is virtually assured in the 100th Congress. Whether such action will result, however, in meaningful protections for older Americans against the potentially ruinous effects of high-cost illness remains to be seen.

This paper presents an overview of the acute care sources of catastrophic medical costs for those over the age of 65, the existing mechanisms for protection against such costs and their adequacy, and the major proposals which have been developed by the Administration, the Congress, and other public policy planners in response to growing awareness of the potential impact of high-cost illness. This paper also provides policy guidelines that may prove useful in the evaluation and/or the development of effective, targeted solutions to the problem of catastrophic medical costs.

It should be noted that the primary focus of this paper is on acute care catastrophic costs for older Americans. Such an orientation, however, should not be construed to mean that acute care medical costs are the primary source of financial risk for this group; indisputably, long-term care costs represent the single greatest source of potentially catastrophic costs for the elderly.

Acknowledgment:

The author wishes to thank Marilyn Moon, Director, and Mary Jo Gibson, Policy Analyst, Public Policy Institute, American Association of Retired Persons for their valuable contributions to this report.

Neither should the exclusion from this discussion of high-cost illness for non-elderly Americans suggest the absence of a problem for that population. That more than 35 million Americans under the age of 65 have no health care coverage, either public or private, is a national shame that is at least as significant as the unclosed gaps in health care coverage which leave millions of older Americans vulnerable to unmanageable medical expenses.

Neverthless, while both of these issues -- long-term care and health care for the uninsured -- merit vigorous remedial action, comprehensive legislation concerning these areas is not expected in the 100th Congress. These issues must not be neglected in the belief that legislation on acute care catastrophic protections for older Americans enacted in 1987/1988 will solve this country's catastrophic illness problems.

II. DEFINING CATASTROPHIC ILLNESS

Catastrophic illness has been defined variously, some definitions relying on fairly subjective descriptions of financial catastrophe and others attempting to quantify precisely the catastrophic experience. The three most widely cited definitions of catastrophic illness include:

1. Flat dollar expenditures for medical care, either incurred or out-of-pocket;
2. Particular diseases or medical conditions;
3. Expenditures for medical care expressed as a percent of income, or "thresholds," as characterized by Trapnell, Mays and Tallis, that "reflect different degrees of sacrifice or financial consequences...." [1]

Clearly definitions #1 and #2 ignore the potential for financial ruin that can accompany even modest medical expenditures when health care coverage is absent or inadequate, and when income and other resources are insufficient to cover medical costs without producing undue hardship. Wyszewianski has developed useful catastrophic "pairings" that illustrate the distinction between medical care expenditures that are large or "catastrophic" relative to ability to pay, and those that are considered "high-cost" because they exceed a designated amount. These pairings of "catastrophic" and "high-cost" attributes, which take into account the availability and the adequacy of third party health care coverage and personal resources, include:

1. Both "catastrophic" and "high-cost;"
2. "High-cost" but not "catastrophic;"
3. "Catastrophic" but not "high-cost." [2]

S.E. Berki makes similar distinctions. Families with very high incomes (i.e., $100,000 per year) may find even extraordinary medical bills manageable. But Berki notes that low-income families without health insurance may find "low-cost diseases" (i.e., those involving outlays of less than $2,000) financially disastrous. He reports that in 1977 80% of those families who spent more than 10% of their income on health care actually spent less than $2,000 in the course of the year. [3]

Clearly, any adequate definition of catastrophic illness must take into account the financial means of the individual or family faced with either "low-cost" or "high-cost" medical problems. In this paper, catastrophic illnesses are defined as those illnesses or medical conditions that impose unmanageable financial burdens on families, forcing them to forego needed medical care or other day-to-day essentials.

III. ELDERLY HEALTH CARE EXPENDITURES

There is no question that the Medicare and Medicaid programs have had a profoundly beneficial effect on access to health care by the elderly, the disabled, and the poor. But significant numbers of these individuals remain at risk for sizable out-of-pocket health expenses; in some cases, they may even be forced to forego essential medical care because of incomplete and variable levels of health care coverage.

Since 1966, the portion of the elderly's health care bill covered by government spending has almost doubled, while that portion paid directly by older Americans themselves has been reduced by half. Between 1984 and 1986 alone, Medicare expenditures for those over the age of 65 rose from $55.67 billion to $67.2 billion. In 1986, $40.99 billion, or 61% of total Medicare outlays, was spent on inpatient hospital care, and $17.7 billion (26% of the total) flowed to physicians. About $590 million (or less than 1% of the total) was spent by Medicare in 1986 on skilled nursing facility services for older Americans. [4]

Approximately 3.5 to 4 million older Americans, or 15% of the elderly population, are covered by Medicaid. In fiscal year 1985, Medicaid expenditures for the elderly exceeded $14 billion, of which more than two-thirds ($9.6 billion) was spent on nursing home care. [5]

The accomplishments of the Medicare and Medicaid programs have been considerable, especially as they are reflected in greater access to health care and improved health status of elderly persons. Nevertheless, it would be a mistake to infer that older Americans are now insulated from the high cost of health care. In fact, Medicare today covers less than one-half of the total elderly health care bill which will likely approach $170 billion in 1987. Although Medicaid picks up another 13%, the beneficiary himself is responsible for fully one-third of the total, either directly out-of-pocket or indirectly through private health insurance premium payments.

Indeed, older beneficiaries today spend as large a portion of their income on their health care needs (15%) as they did before the existence of Medicare. It is projected that in 1987 they will spend, on average, more than $1,900 out-of-pocket to cover the cost of their health care, an amount that includes expenditures for Medicare-covered services, non-covered services, and insurance premiums. Moreover, out-of-pocket medical expenditures for older Americans continue to rise at a faster rate than do their incomes; such expenditures are expected to consume, on average, almost 20% of elderly annual income by the year 2000.

IV. THE ACUTE CARE CATASTROPHIC RISK FOR OLDER AMERICANS

For older Americans who have Medicare coverage, an acute care illness is less likely to result in a catastrophic burden than a long-term illness. But Medicare's coverage of acute care is by no means without significant gaps, gaps which if not supplemented by other forms of insurance, leave individuals vulnerable to devastating medical costs. Chart 1 shows that a Medicare beneficiary with two hospital stays would, on average, incur out-of-pocket expenses that would total nearly $3,000 without private supplemental insurance and would even exceed $1,600 with an average insurance policy.

Medicare beneficiaries' liability for acute care medical costs consists of two components: (1) Medicare cost-sharing requirements (i.e., deductibles and coinsurance) for covered services, and (2) expenditures for non-covered medical services and goods. It is important to distinguish between these two categories of liability since most of the catastrophic "cap" plans that have been proposed permit the former (coinsurance and deductible amounts) to be counted toward the cap but exclude the latter (expenditures for non-covered services and goods). And the second category of liability is by no means insignificant; it is estimated that, on average, for every $1.00 beneficiaries incur in coinsurance and deductibles, they spend an additional $.50 to $1.00 for non-covered services and goods. Moreover, Feder has noted that half the elderly's catastrophic costs are for services not covered by Medicare. [6]

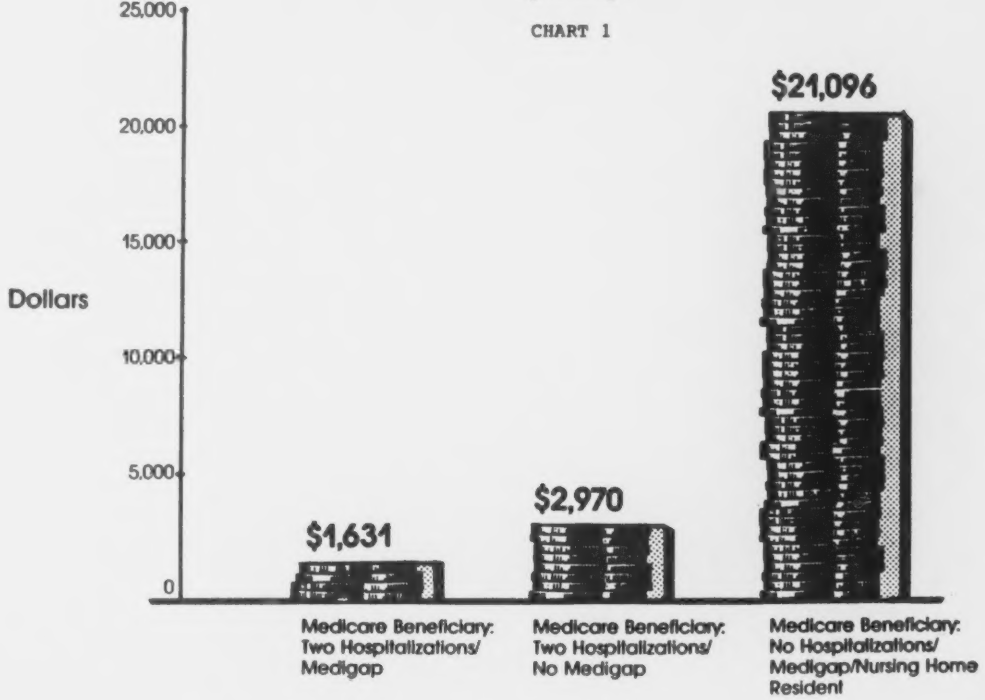
A. Medicare Deductible and Coinsurance Liability

Under Medicare Part A, beneficiaries are required to pay a hospital deductible in each benefit period approximately equal to the cost of one day of hospital care. Between 1980 and 1987, the hospital deductible rose from $180 to $520, an increase of 189%. Because of the sensitivity of the formula used in calculating the deductible to declining lengths of stay, the deductible has risen especially dramatically since the implementation of the Medicare Prospective Payment System (PPS). As a result of legislation enacted in 1986, the hospital deductible will be indexed in the future to increases in hospital rates.

Beneficiaries are also responsible for coinsurance for days 61 through 90 of hospital use, an amount calculated at one-fourth of the hospital deductible. For each lifetime reserve day (days 91 through 150), beneficiaries are required to pay an amount equal to one-half the hospital deductible, or $260 per day in 1987. While there is no deductible for skilled nursing facility (SNF) services, Medicare beneficiaries this year will pay $65 per

ANNUAL OUT-OF-POCKET MEDICAL EXPENSES FOR THREE MEDICARE BENEFICIARIES (1987)

CHART 1



Source: Based on Congressional Budget Office preliminary estimates.

day (one-eighth the hospital deductible) to satisfy coinsurance requirements for days 21 through 100 in a SNF.

Approximately 23% of Medicare enrollees are admitted to a hospital at least once in a given year. But only about .5% of Medicare enrollees (158,000 in 1984) use more than 60 hospital days in a benefit period, thereby triggering coinsurance requirements. Of these, only .1% or 32,000 enrollees will exceed 90 days in hospital in a benefit period (Charts 2 and 3). [7]

In 1986, Medicare beneficiaries incurred $4.3 billion in Medicare hospital deductible and coinsurance liability. This amount represented an increase in such aggregate liability of more than 169% between 1980 and 1986. The largest portion of total cost-sharing liability for hospital care is attributable to the hospital deductible. In 1986, Medicare beneficiaries incurred $3.7 billion in hospital deductible liability and only $600 million in hospital coinsurance liability. [8]

In 1986, fewer than 1% of Medicare beneficiaries used any Medicare-reimbursed SNF services. Of this group only slightly more than half or about 183,000 enrollees triggered SNF coinsurance by using more than 20 days of SNF care in a benefit period. Coinsurance liability for such stays reached $243 million in 1986, up by 143% since 1980. [9]

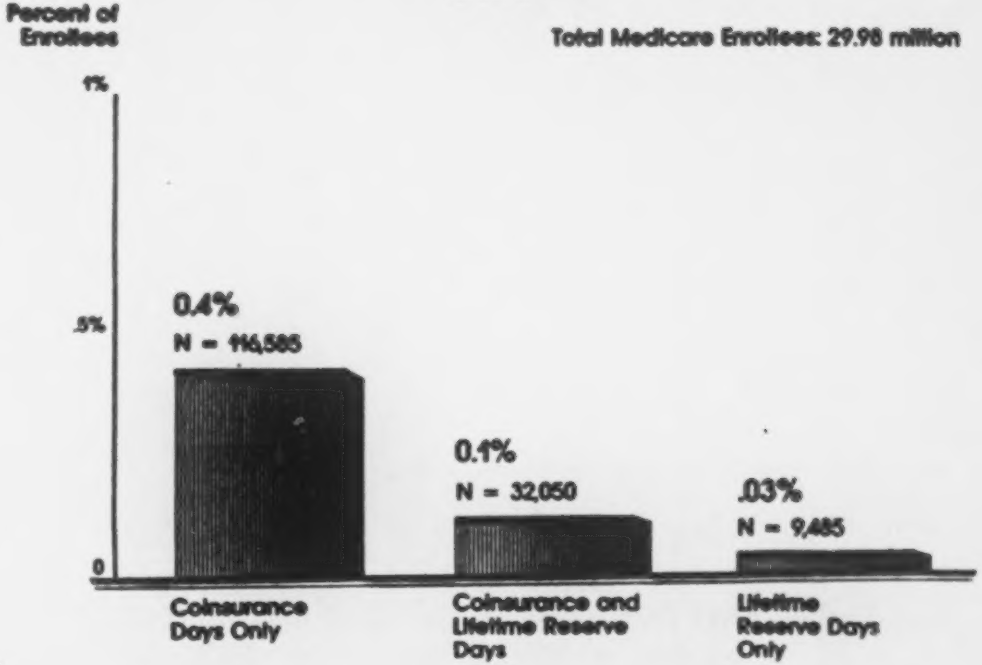
Beneficiaries share especially heavily in the cost of Medicare Part B services, largely in connection with the use of physician services. Each beneficiary must meet a $75 annual Part B deductible, and is also responsible for 20% of the amount that Medicare deems "reasonable" for a particular service. (In addition, beneficiaries whose doctors do not accept assignment are fully responsible for the amount their doctor charges above the Medicare-approved rate.)

Cost-sharing requirements under Medicare Part B represent a far greater financial burden on Medicare beneficiaries than do cost-sharing requirements under Medicare Part A. In 1986, Medicare beneficiaries incurred $5.7 billion in Part B coinsurance liability and $1.7 billion in Part B deductible liability. The most striking rate of incease in physician-related liability has occurred in coinsurance liability which in the aggregate has risen by 170% since 1980 (Chart 4). [10] Further, coinsurance liability which in 1975 accounted for about 20% of total physician service liability accounted for fully 32% of such liability in 1985 (Chart 5). [11] Finally, increases in Part B coinsurance expenditures have far outpaced increases in Social Security benefits (Chart 6).

PERCENT OF MEDICARE ENROLLEES USING HOSPITAL COINSURANCE DAYS AND LIFETIME RESERVE DAYS

1984

CHART 2



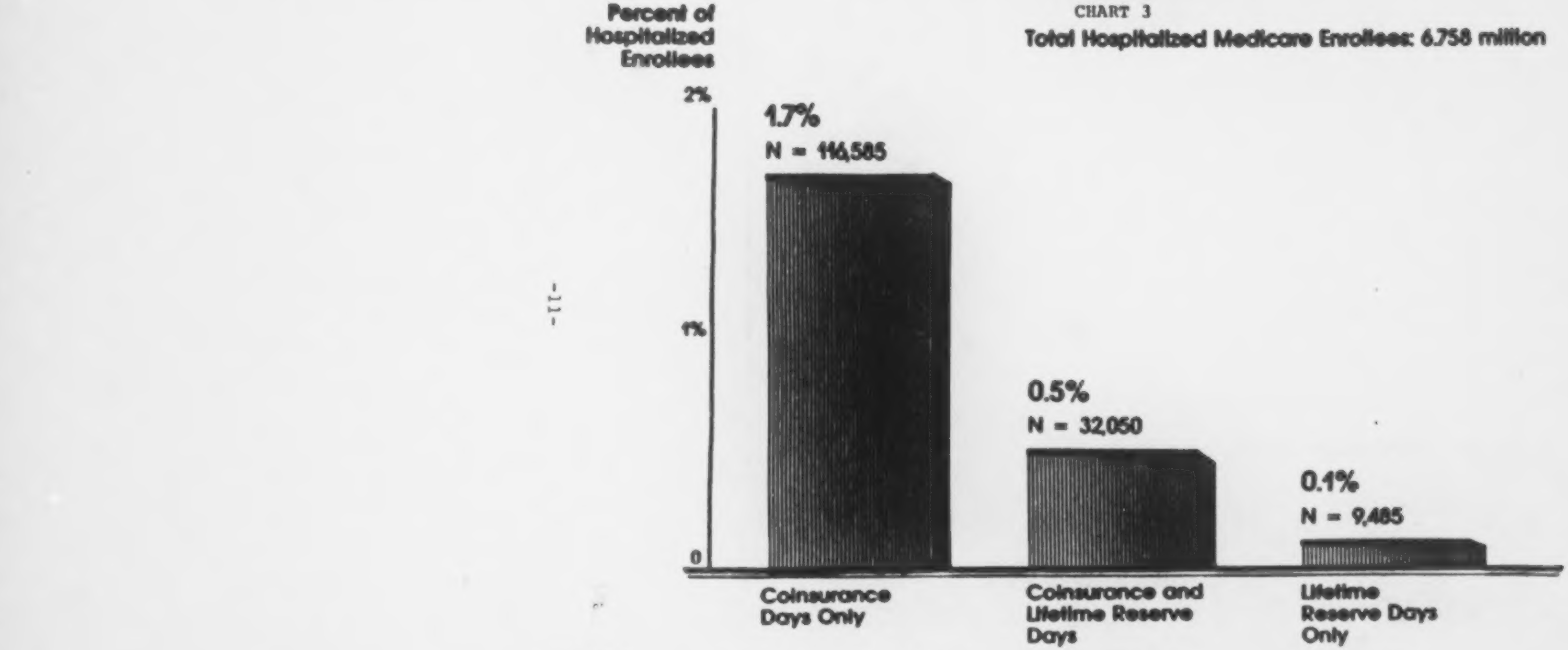
Source: HCFA
February 1986

Note: Coinsurance Days: 61-90 days of hospital care
Lifetime Reserve Days: 91-150 days of hospital care (non-renewable)

PERCENT OF HOSPITALIZED MEDICARE ENROLLEES USING HOSPITAL COINSURANCE DAYS AND LIFETIME RESERVE DAYS
1984

CHART 3

Total Hospitalized Medicare Enrollees: 6.758 million

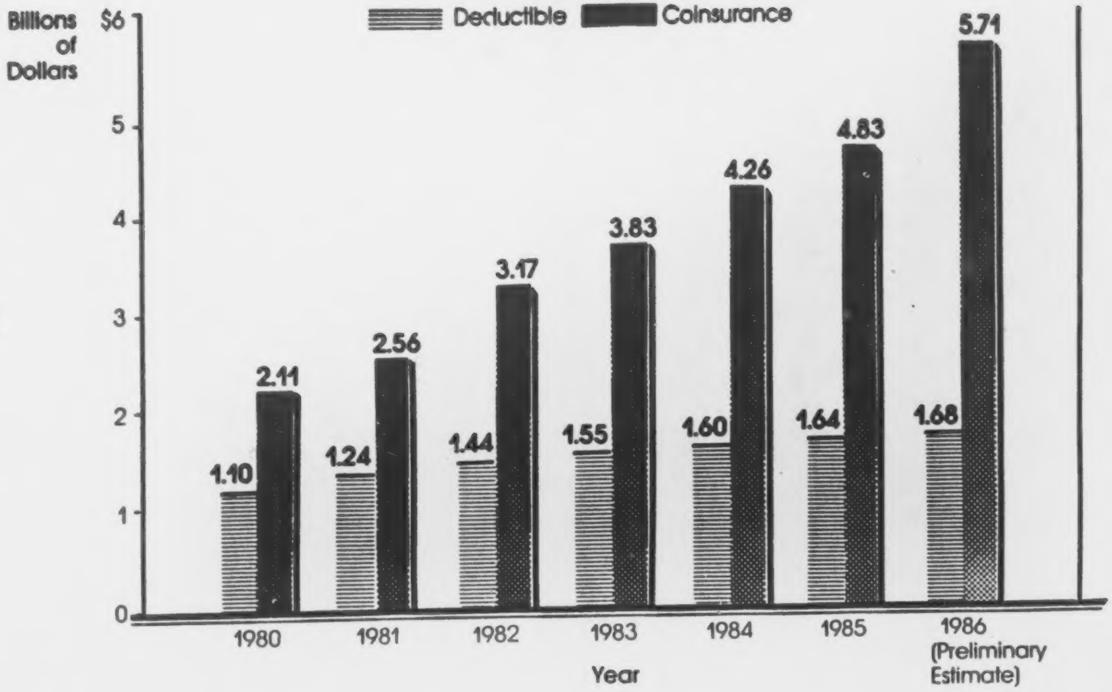


Source: HCFA
February 1986

Note: Coinsurance Days: 61-90 days of hospital care
Lifetime Reserve Days: 91-150 days of hospital care (non-renewable)

MEDICARE PART B
DEDUCTIBLE AND COINSURANCE LIABILITY FOR THE AGED*

CHART 4

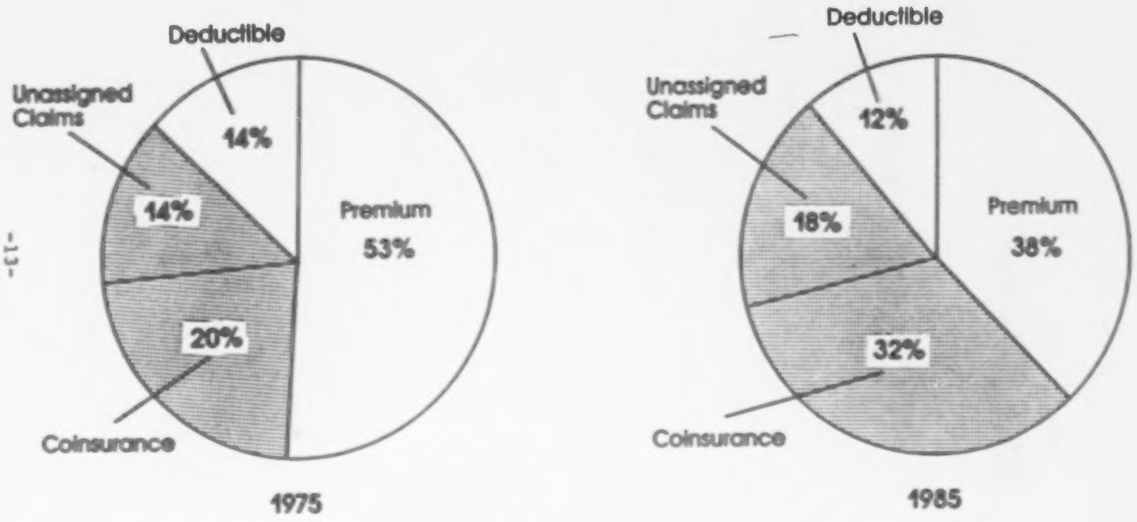


*Includes Physicians and Other Medical Suppliers

Source: HCFA, Office of the Actuary, January 1987.

BENEFICIARY LIABILITY FOR MEDICARE-COVERED PHYSICIAN SERVICES

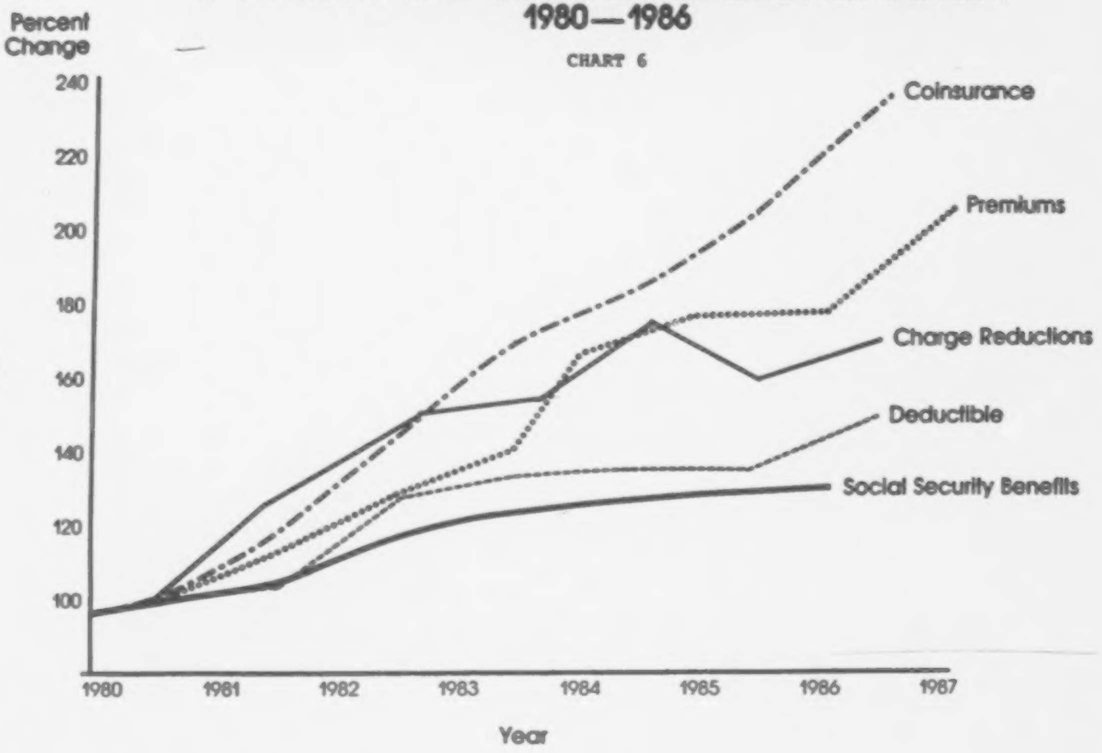
CHART 5



Source: HCFA

COMPARISON OF CUMULATIVE CHANGE IN SOCIAL SECURITY BENEFITS AND COMPONENTS OF MEDICARE PART B LIABILITY 1980—1986

CHART 6



Source: HCFA: Social Security Bulletin

Whereas only about one-fourth of Medicare beneficiaries will incur liability from the use of hospital services and/or SNF services in a given year, 80% will incur liability from the use of physician services during the same period. Further, only .5% of beneficiaries will trigger hospital coinsurance charges, but fully 60% of beneficiaries will incur coinsurance liability for physician services.

B. Acute Care Medical Services and Products Not Covered by Medicare

In addition to Medicare's cost-sharing requirements for covered services, beneficiaries also face significant out-of-pocket costs for those acute care medical services and products which Medicare does not cover or which, in the case of certain services, are subject to Medicare's durational limits. These acute care services and goods include:

- Outpatient prescription drugs
- Balance billing by physicians (sometimes known as "charge reductions" on non-assigned claims)
- Dental services/products
- Optical services/products
- Hearing services/products
- Routine physican examinations, influenza shots, Pap smears, mammograms, etc.

(1) Outpatient Prescription Drugs - Outpatient prescription drugs can impose special financial burdens on those over 65 because so many elderly people are required to take medications on a regular, outpatient basis and because prices for prescription medications have dramatically outstripped cost-of-living increases in Social Security benefits.

Data from the National Medical Care Expenditure Survey indicate that in 1977 75% of those over 65 filled at least one prescription during the course of the year. For this group, the rate of use of prescribed medications in 1977 was 14 per person. [12]

A recent AARP survey suggests that about 62% of individuals over the age of 65 take prescription drugs on a regular basis. According to the survey results, of those regular users of prescription drugs whose health coverage plans provided any drug coverage, 25% spent more than $360 out-of-pocket on prescribed medications in 1986. Of those regular users who received no financial assistance with drug costs in 1986, fully 40% spent more than $360 on medicines in that year. [13] It should be stressed that these figures apply only to self-described regular users of prescription medicines, whose drug expenditures are apt to be significantly higher than those of the general elderly population.

A dramatic rise in the price of prescription drugs began in 1981, and since then, drug prices have far outstripped other medical components of the Consumer Price Index (CPI). Between 1981 and 1985, prescription drug prices rose by 56%, while the overall CPI increased by only 23%. And there is little evidence that this trend is abating. In 1986, prescription drug prices rose at four times the rate of general inflation. [14]

(2) Balance Billing by Physicians - The second largest source of out-of-pocket liability for acute care services not covered by Medicare derives from Medicare's assignment rules. Under the Medicare program, physicians are free to determine if they will accept Medicare assignment for their patients, that is, accept Medicare's determination of the "reasonable" charge for a particular service as payment in full. Beneficiaries whose doctors accept assignment pay only a $75 annual deductible and the 20% coinsurance on Medicare's "reasonable" charge. Beneficiaries whose doctors do not accept assignment are additionally responsible for the amount their doctor charges above the Medicare-approved rate. This excess charge is variously known as a "charge reduction" or "balance billing."

Between 1980 and 1986, beneficiary liability for charge reductions on unassigned physician claims almost doubled, from $1.45 billion in 1980 to $2.8 billion in 1986 (Chart 7). [15] This increase is partly the result of growth in the size of individual charge reductions. In 1971, physician charges submitted to Medicare were reduced on average by 11.4% before reimbursement. By 1985, this amount had grown to 26.9%. [16] The beneficiary whose doctor does not accept assignment bears the full financial burden of such charge reductions.

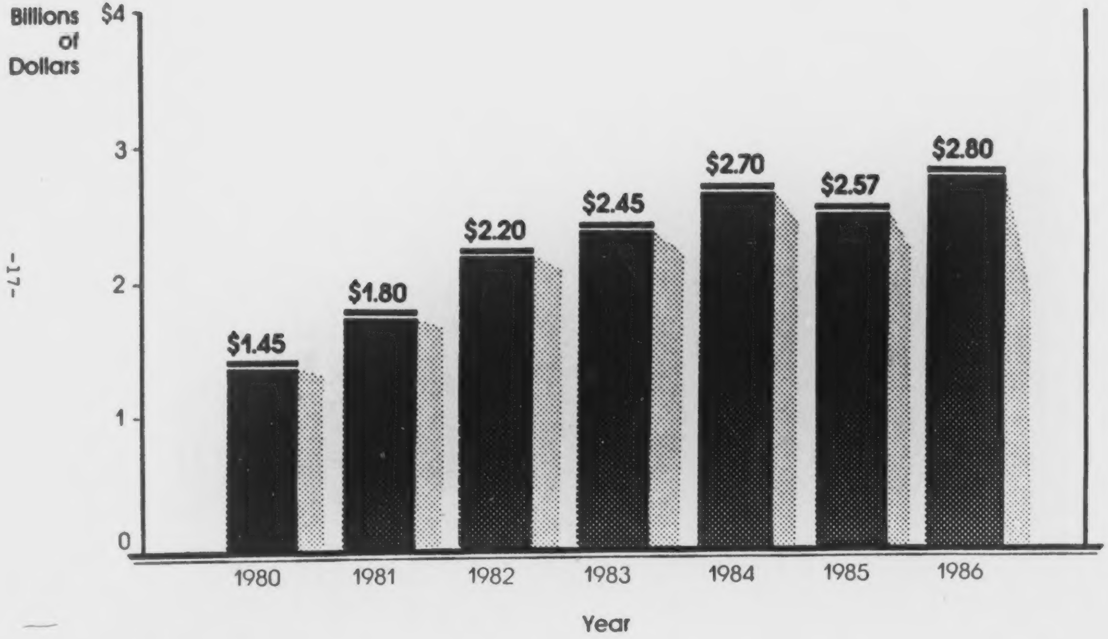
The percentage of elderly people affected by physician unwillingness to accept assignment is considerable, up from 70% in 1975 to 80% in 1982.* [17] Moreover, there is considerable disparity across states in the percent of elderly beneficiaries

---

* While the Health Care Financing Administration is unable to update these figures beyond 1982, one might reasonably expect that the implementation of the Medicare participating physician program in 1984 slowed or reversed the upward trend described here.

CHARGE REDUCTIONS ON UNASSIGNED MEDICARE PART B CLAIMS*

CHART 7



*Includes Physicians and Other Medical Suppliers

Source: HCFA

with unassigned claims, from a low of 51% in Rhode Island to a high of 95% in Oregon. Similar disparities in assignment rates exist across medical specialty groups. [18]

Given the magnitude and unpredictability of beneficiary liability stemming from unassigned claims, the physician's decision to accept or reject assignment can be critical to the individual beneficiary. Under Medicare's "participating physician" arrangement, 28.4% of physicians treating Medicare patients in 1986 agreed contractually to accept assignment for all Medicare claims, a disappointing drop of more than two percentage points over 1985. [19]

Moreover, there exists a great disparity from state to state in the percentage of participating physicians, ranging from a low of 8% in South Dakota to a high of 54% in Alabama (1986). A similar disparity in participation rate exists across specialities, with a low of 22% for anesthesiologists to a high of 46% for nephrologists. [20]

With the implementation of the "participating physician program" came significant improvement in the Medicare assignment rate, that is, in the percentage of total Medicare claims submitted on an assigned basis.

In 1985 the overall assignment rate was 68.5%, up dramatically from the 1984 rate of 59%. Moreover, gains seen in assignment rates in 1985 seem to have held in 1986 when assigned claims made up 68% of total claims submitted (Table 1).

Table 1

Medicare Part B Assignment Rates: 1968-1986 [21]

Year	Percent of Claims Assigned
1968	59.0
1970	60.8
1972	54.9
1974	51.9
1976	50.5
1978	50.6
1980	51.5
1982	53.0
1984	59.0
1985	68.5
1986	68.0

There, of course, remains significant variability in assignment rates across states. In 1986, 92% of claims submitted in Massachusetts were assigned, while only 35% were assigned in South Dakota. [22] Similar disparities in assignment rates are reflected across specialties, as well.

In spite of the apparent improvements in assignment rates during the last few years, beneficiary liability associated with unassigned physician claims rose from $2.57 billion in 1985 to $2.8 billion in 1986, after actually declining between 1984 and 1985 (Chart 7, page 17). This recent increase in unassigned claim liability during a period characterized by high assignment rates suggests possible increases in volume, the use of more expensive physician services, the influence of the two percentage-point decline in the physician "participation" rate between 1985 and 1986, or a combination of these three factors.

(3) Dental and Optical Services/Supplies - Dental and optical services and supplies constitute yet another significant source of out-of-pocket liability for older Medicare beneficiaries. Although a smaller portion of the elderly population uses dental care than the general population, elderly expenditures for such care are by no means trivial. ICF Incorporated has estimated that in 1986 older Americans spent $2.3 billion out-of-pocket for dental care. This amount, according to ICF Incorporated, is equal to 85% of all expenditures on dental care for the elderly. In the same year, older Americans also spent $1.4 billion on eyeglasses and other vision aids, an amount which more than tripled between 1978 and 1986. [23]

V. THE AVAILABILITY AND ADEQUACY OF EXISTING CATASTROPHIC PROTECTIONS FOR OLDER AMERICANS

A. Medigap

The gaps in Medicare's coverage, particularly its cost-sharing requirements (i.e., deductibles and coinsurance), have led to the development of private supplemental insurance plans, so-called "Medigap" policies. About 70% of Medicare beneficiaries are covered by such plans. Since the enactment of the Baucus amendment in 1980, Medigap plans are required to cover: (1) hospital coinsurance; (2) 90% of Part A expenses after exhaustion of the lifetime reserve to a lifetime limit of 365 additional days; and (3) the 20% coinsurance on Medicare Part B services. Such plans are not required to cover either the hospital or physician service deductible, although most offer coverage of the former. Finally, the plans may impose their own deductible of up to $200 per year for Part B coverage with a maximum Part B benefit of not less than $5,000.

In spite of the Baucus amendment, there is great variability in the depth and scope of the Medicare population's private insurance coverage. This is in part the result of the restriction of the Baucus provisions to only non-group insurance policies issued as "Medicare supplements" on or after July 1, 1982. Certain categories of insurance are exempt from compliance with the Baucus legislation; these include employment-related group insurance, conversions from group to individual policies, and policies already in effect on July 1, 1982.

In 1977, 98% of Medicare beneficiaries were covered through their private insurance plans for hospital care, 88% for inpatient physician care, 65% for outpatient diagnostic services, and 62% for physician office visits. It has been projected that if all non-group insurance were to meet the minimum standards of the Baucus amendment, the scope of coverage of Medicare beneficiaries would rise to 99% for hospital care, 97% for inpatient physician care, 94% for outpatient diagnostic services, and 91% for physician office visits. [24]

Similar improvements could be expected in the depth of coverage of the Medicare population if all non-group plans conformed to the minimum standards of the Baucus legislation. Full coverage of Part A coinsurance for hospital days 61 through 90 would rise from 87% of privately covered enrollees to 96%, and full coverage of Part A coinsurance for days 91 through 150 would rise from 74% to 94%. Further, the proportion of those individuals with at least partial coverage of days 151 through

365 in a hospital would nearly double, while the proportion with no coverage of these days would drop dramatically. [25]

Those with full coverage of the Medicare Part B 20% coinsurance on Medicare's allowable charge (for inpatient visits) would increase from 81% to 96% of all privately insured Medicare beneficiaries. Gains would be even more dramatic for full coverage of the Part B coinsurance on allowable charges in the physician office setting (from 60% to 90% of all privately insured Medicare beneficiaries). [26]

Compliance by all non-group plans with the provisions of the Baucus amendment would, of course, do nothing to improve Medigap coverage of services and products not already covered by Medicare. Most significant among these are prescription drugs (only 41% of beneficiaries with private supplemental insurance have any level of coverage of out-patient prescribed medicines), dental services and goods, and optical services and goods. Further, such compliance would not result in increased coverage of balance billing or the difference between Medicare's allowable charge and the actual charge of the physician who does not accept assignment. Only about one-half of all privately insured Medicare beneficiaries have any degree of protection against balance billing by physicians, although far more actually incur this kind of out-of-pocket liability. [27]

Medigap plans range in cost from $150 per year to more than $1,200 per year. Regardless of the premium level, some plans may be very costly relative to the benefit returned to the insured. The Baucus amendment requires that Medicare supplemental group plans return at least 75% of premium income to enrollees in the form of benefits; the required minimum benefit payout -- for non-group plans is set at 60% of premiums. A recent study by the General Accounting Office (GAO) indicates that over 60% of commercial insurance policies with premium incomes below $50 million in 1984 did not meet minimum loss-ratio requirements.[28]

Because of the technical terminology featured in many Medigap plan descriptions and the complex relationship between Medicare benefit coverage and Medigap benefit coverage, Medicare enrollees may find it difficult to compare plans, to weigh costs versus benefits, and to determine the degree to which they are at risk for various kinds of medical incidents. It is undoubtedly confusion over their coverage as well as their aversion to risk that has led many Medicare beneficiaries with private coverage to carry more than one Medicare supplemental insurance policy. In fact, of the more than two-thirds of beneficiaries with private supplemental coverage, 17% carry two or more such policies and 3% carry three or more. [29] While the full extent of duplicative coverage is not known, it is apparent that a significant portion of Medicare beneficiaries may be carrying superfluous supplemental coverage which is not only costly but likely to create benefit coordination problems, as well.

B. Medicaid

It is reassuring to believe that the Medicaid program serves to protect elderly beneficiaries from potentially catastrophic acute care out-of-pocket expenditures; but this is not necessarily the case. The Congressional Budget Office (CBO) reports that in 1986 only 27% of all elderly people with family incomes below $5,000 were covered by Medicaid (Chart 8). [30] How can this be? We have only to look to the variability in Medicaid's eligibility requirements across states for an answer. There exists no national mandatory income standard for Medicaid eligibility, no mandated coverage of the "medically needy," and no uniformity in eligibility for a Medicaid "buy-in" of Medicare Part B coverage.

In a study entitled "The Dually Entitled Elderly Medicare and Medicaid Population Living in the Community," McMillan and Gornick note that in 1980, 3.2 million elderly Medicare beneficiaries (14% of the elderly non-institutionalized population) were also entitled to Medicaid. These individuals are known as the "dually entitled" or "crossovers." Not all of them are poor; a significant number "spent down" to the Medicaid eligibility level as the result of large medical expenses.

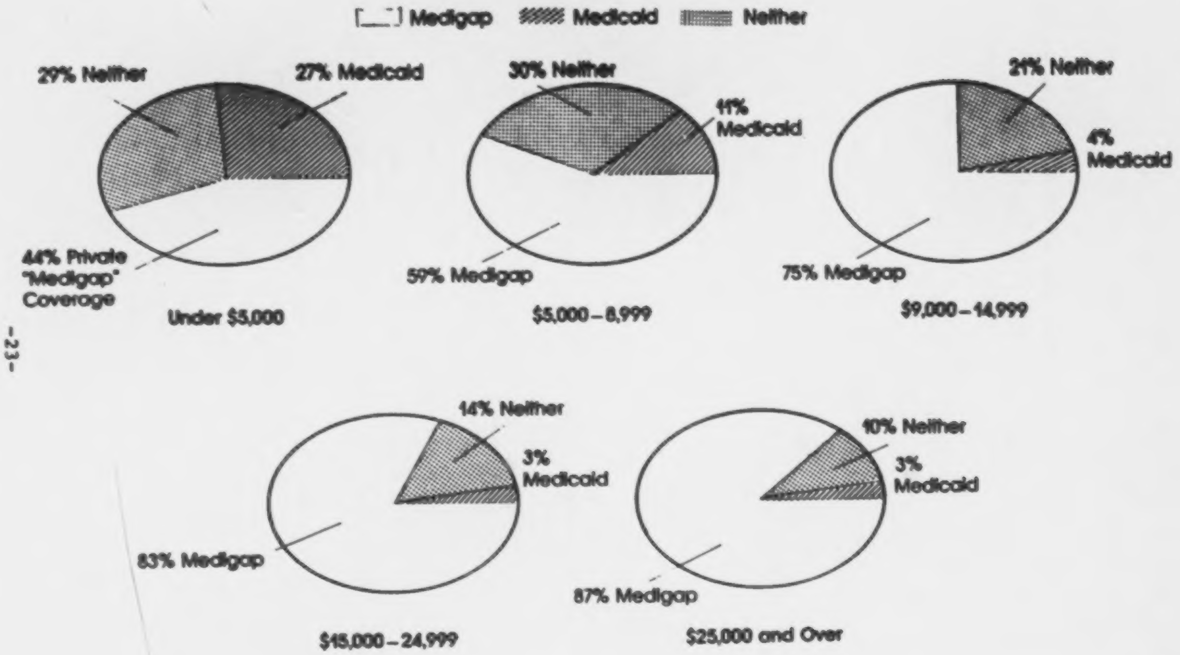
The median age for the crossover population was 73.6 years. Seventy percent (70%) were female, and 24% were non-white. The median age for those elderly people without Medicaid coverage was 72 years. Sixty percent (60%) of this group were females and only 8% were non-white. [31]

The crossovers living in the community had significantly lower incomes than those covered by Medicare only. While 10% of those without Medicaid had family incomes at or below the official poverty level, 43% of the crossovers fell into this income category. Thirty-six percent (36%) of the crossovers had family incomes between 101% and 200% of the poverty level compared with only 31% of those covered solely by Medicare. Among the crossover population, 21% had family income greater than 200% of the poverty threshold compared with 59% for those elderly persons without Medicaid. [32]

In 1980, 54% of the cost of all health care for the crossovers living in the community was paid for by Medicare, with Medicaid paying a 31% share. Out-of-pocket costs for this group represented a 9% share, an amount much lower than the 21% share paid by Medicare beneficiaries without Medicaid coverage. [33]

MEDIGAP/MEDICAID COVERAGE FOR OLDER AMERICANS, 1984*

CHART 8



*By Family Income.

Source: Congressional Budget Office.

Medicaid picked up 27% of the cost of hospital services for the crossover population with Medicare paying another 61%. The individual was responsible for only a 6% share of total hospital costs. This compares with an 8% out-of-pocket share for those Medicare beneficiaries lacking Medicaid coverage. [34]

Medicaid made an even greater contribution (41%) toward the cost of physician services for the crossovers, and Medicare contributed an additional 42.3% toward total physician costs for this group. Still, the elderly Medicaid recipient had to pay more than 10% of his physician service costs out of his own pocket. His non-Medicaid-covered counterpart, of course, paid a far greater share (36%) of physician service costs in 1980. [35]

For dental services for the crossover group, Medicaid paid 42% of the total, while the recipient absorbed a 50% share out-of-pocket. Because Medicare and Medigap plans cover virtually no dental services, the Medicare recipient without Medicaid protection paid 88% of the cost of dental care himself. [36]

A similar situation exists with respect to prescribed medicines. Medicaid's share of the cost of prescribed medicines for those entitled to both Medicare and Medicaid was 64% in 1980, the recipient assuming responsibility for another 25%. The elderly Medicare beneficiary without benefit of Medicaid coverage paid an out-of-pocket share that was three times greater than his dually entitled counterpart.

While Medicaid certainly affords more comprehensive coverage to the crossover population than is available to those elderly individuals living in the community without such protection, it is clear that protection of these dually entitled beneficiaries is not total. Out-of-pocket shares of 6% for hospital charges, 10% for physician charges, 25% for prescribed medicine charges and 50% for dental charges are by no means insignificant, neither for the poor elderly crossover or for those "medically needy" crossovers who have spent down to Medicaid eligibility levels.

C. The Vulnerable Elderly

Who among the elderly are most vulnerable to acute care catastrophic costs? Surely the answer must include those who are not able to afford Medigap coverage, but who also do not qualify for Medicaid coverage. For more than 20% of the elderly, Medicare represents the only source of protection. Significant numbers in this group are frail, very old, low-income, and uniquely vulnerable to the cumulative financial burden resulting from Medicare coinsurance and deductibles and from the costs of all non-covered services and goods.

Cafferata and Meiners note that persons over the age of 75 make up about half of those lacking both Medicaid and private supplemental insurance; about 60% of this group have incomes at or near the poverty level. Although these individuals use fewer health services than do the privately insured, when they do use such services, their out-of-pocket expenditures tend to be higher than for their more adequately insured counterparts. Further, the impact of their out-of-pocket expenses on income is far more dramatic than it is for the privately insured or those covered by Medicaid (Table 2). [37]

A second group worthy of particular concern includes the poor/near poor who feel compelled to buy Medigap insurance but who can ill afford it. Almost half of elderly people with less than $5,000 per year in family income purchase Medigap plans (Chart 8, page 23). [38] Even if the coverage selected is modest, the premium payments for such plans must constitute a considerable drain on already meager resources. One can only surmise that individuals buying these plans must forego certain day-to-day essentials to meet their premium payment obligations.

TABLE 2

Elderly Annual Out-of-Pocket Expenditures for Personal Health Care Services* as a Percent of Income By Type of Insurance Coverage: 1977

	Population (1,000s)	Out-of-Pocket Expenditures for Personal Health Services as a Percent of Personal Income: Excluding Health Insurance	Including Health Insurance
		Percent	
All persons 65 years and older	21,987	14.4	23.6
Type of Insurance Coverage			
o Medicare only	4,360	27.8	33.1
o Medicare & Medicaid only	2,309	6.7	6.7
o Medicare & Private	14,376	11.7	23.9
Group Plans	5,417	10.4	17.3
Non-group Plans	8,959	12.5	27.9

* Both including and excluding health insurance premiums.

Source: Cafferata and Meiners, "Public and Private Insurance and the Medicare Population's Out-of-Pocket Expenditures: Does Medigap Make a Difference," NCHSR Draft Report, May 1985. Table above is based on Table 2 of NCHSR report.

VI. THE MAJOR CATASTROPHIC ILLNESS PROPOSALS*

The catastrophic illness insurance proposal developed by Otis R. Bowen, the Secretary of Health and Human Services, and submitted to President Reagan in the fall of 1986 has had a major impact on the disposition of the catastrophic illness issue: it has heightened public awareness of the issue; it has animated and shaped the congressional debate on the issue; and, to a large extent, it has served as a model in the subsequent development of more highly refined and more generous proposals addressing the issue.

The following discussion of six major catastrophic proposals is not intended to be exhaustive in its scope. It is intended to incorporate the range of the catastrophic options which continue to receive serious consideration in the legislative process.

A. The Bowen Proposal

Secretary Bowen's original proposal included three elements: protections against catastrophic costs associated with long-term care; protections against catastrophic acute care costs for those under the age of 65; and protections against catastrophic acute care costs for those over the age of 65.

The Secretary's proposal for dealing with long-term care costs largely consisted of recommendations to: (1) educate the public about the costs of long-term care and the risk of their incurring such costs; (2) create an environment in which the sale of private long-term care insurance plans would flourish; and (3) encourage the use of medical IRAs (Individual Retirement Accounts) in combination with private long-term care insurance coverage as the means by which individuals could personally assume responsibility for their own long-term care needs.

The Secretary's recommendations for dealing with the catastrophic risk to people under the age of 65 reflected similar reliance on private-sector solutions and, particularly, on the power of incentives to effect private-sector solutions. He also looked to the states to develop innovative catastrophic protection schemes for their residents. Under the Secretary's proposal, full tax deductions would be extended to all employers including catastrophic protection in their employee health plans. Additionally, states were urged to consider, among other approaches, the formation of risk pools for the medically uninsurable, loan guarantees for catastrophic medical costs, and proof of catastrophic coverage as a condition of motor vehicle registration.

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* Unless otherwise noted, descriptions of the legislative proposals considered here are current as of June 5, 1987.

The clear focus of Secretary Bowen's proposal, of course, was on the development of acute care catastrophic protections for those over the age of 65. Here the Secretary departed from his reliance on private sector and state-oriented solutions, and instead recommended that the Medicare program be restructured to include catastrophic protections financed through an additional, actuarially sound premium. It is this element of the Bowen proposal, adopted in its entirety by President Reagan as the Administration's proposal, that has received greatest attention and that has so significantly shaped the ensuing legislative debate.

B. The Administration Proposal (S.592/H.R.1245)

Benefit: The benefit structure of this proposal is based in its entirety upon Secretary Bowen's recommendations for acute care catastrophic protections for those over the age of 65. The proposal consists of two benefit pieces, the first an enhanced Medicare Part A package and the second, a catastrophic "cap" or limit on certain kinds of liability. The plan offers unlimited inpatient hospital days (through the elimination of hospital coinsurance and lifetime limits), subject to two hospital deductibles per year. It also eliminates skilled nursing facility (SNF) coinsurance, but leaves unchanged the 100-day limit on Medicare's coverage of SNF services. Additionally, through its "cap" provisions, the plan would limit the beneficiary's liability for all Medicare deductibles and coinsurance to $2,000 per year.

Financing: The expanded Medicare protection package would be financed through an increase in the monthly Part B premium, which would be adjusted each year to cover increases in the cost of the catastrophic benefit. It is estimated that the monthly premium for this benefit in 1988 would be $6.10. This amount would be added to the beneficiary's current Part B premium.

The catastrophic benefit would be optional only to the extent that Medicare Part B coverage is optional; an individual electing enrollment in Medicare Part B would automatically receive the catastrophic benefit and be charged accordingly. To reject the catastrophic benefit would be to reject enrollment in the Medicare Part B program.

Comment:

1. The Administration proposal's recommendations for an improved hospital benefit superficially seem quite generous. The hospitalized beneficiary would be entitled to unlimited hospital care subject to two annual hospital deductibles each year. He would no longer be liable for coinsurance between the 61st and 150th day of hospitalization, nor would he pay any of the costs of hospitalization beyond the 150th day.

   Actually, however, only 158,000 Medicare enrollees (or less than 1% of total enrollees) use any hospital coinsurance days during the course of the year (See Chart 2, page 10). Of this group, about 80% or more than 125,000 enrollees are already protected by Medigap, Medicaid, or a combination of the two. If they have such coverage, they are apt to be well protected for hospital coinsurance liability (given the provisions of the Baucus Amendment), and almost as well protected for the hospital deductible. Thus, only about 30,000 Medicare beneficiaries would appear to "benefit" from the hospital protections provided by the Administration Proposal.

2. It should be noted, as well, that under this plan, beneficiaries are actually subject to a greater number of hospital deductibles than they are under current law. [39] The reason for this is simple. Under current law beneficiaries who currently are readmitted to a hospital within a benefit period pay no additional deductible for the second admission. Under the Administration's catastrophic recommendations, they now would be required to pay this deductible. There are more such cases than there are beneficiaries currently liable for three or more deductibles.

3. The Administration plan also eliminates all SNF coinsurance. This feature would benefit slightly more than half of the .9% of Medicare beneficiaries who use SNF services each year.

4. The catastrophic cap in the Administration plan is set at $2,000 each year for Medicare deductibles and coinsurance. The cap is both high and restrictive. It is estimated that approximately 1.3 million enrollees each year

incur more than $2,000 in coinsurance and deductible liability. About 80% of these individuals (or about 1,040,000 enrollees) have substantial protection for this kind of liability through Medigap, Medicaid, or a combination of the two types of coverage.

It would be a mistake to infer that the remaining 260,000 are "protected" against acute care catastrophic costs by the Administration proposal. These individuals are indeed among the most vulnerable. But a cap of $2,000 on coinsurance and deductibles could hardly be labelled catastrophic "protection" to the individual with only $6,000 to $10,000 per year in family income.

Moreover, the individual incurring $2,000 per year in Medicare coinsurance and deductibles is actually incurring another $1,000 to $2,000 each year for those services and products which do not count toward the cap. No long-term care costs, no prescription drug costs, no balance billing by physicians, no physical examinations, pap smears, flu shots, hearing care, dental care, or visual care count toward the cap under this plan. These represent essential medical services to those over the age of 65.

5. Medicare beneficiaries who tend to be risk aversive and in search of "first dollar" coverage in their Medigap plans would hardly be persuaded by the Administration's benefits in the catastrophic plan to drop their private supplemental insurance. To do so would require them to absorb $2,000 in coinsurance and deductible liability out-of-pocket for which they are now well protected. While it is reasonable to expect that responsible private insurers would respond to the passage of catastrophic insurance legislation with a corresponding offset (i.e., reduction) in Medigap premiums to match their reduction in risk exposure, this response cannot be assumed. Thus, the Administration's use of a $6.10 increase in the monthly Part B premium may itself represent considerable additional liability to the beneficiary. This increase may be insignificant to the more affluent elderly, but to the poor and near-poor, the increase

in the Part B premium itself, in the absence of any special protections for those living at or near the poverty level, may be unmanageable.

C. Dole/Danforth/Domenici/Durenberger/Chafee Proposal (S.754)

Benefit: The Dole et al. bill, also known as the "Medicare Catastrophic Illness Coverage Act," is very similar in structure to the Administration proposal, although it expands somewhat the degree of catastrophic protection provided.

Like the Administration proposal, the Dole bill would provide both unlimited inpatient hospital days, and would limit the beneficiary's liability for hospital deductibles to only one per year. This bill would also eliminate all SNF coinsurance. The Dole bill, like the Administration proposal, would set a cap on the beneficiary's liability for Medicare coinsurance and deductibles, but reduces the cap from $2,000 per year to $1,800 per year.

Further, the Dole plan permits the 20% coinsurance on immuno-suppressive drugs during the first post-transplant year to count toward the cap; in subsequent years, all reasonable charges for such drugs would also count toward the cap. The bill further directs the Secretary of HHS to request the Institute of Medicine to identify other prescription medications which might appropriately count toward the cap.

The Dole plan would modify the home health benefit to permit up to 21 days of continuous nursing home and home health aide services with physician certification.

Financing: The expanded Medicare benefits in the Dole plan are financed by an increase in the current Part B monthly premium sufficient to cover their costs. This additional premium would be adjusted annually to ensure that it would continue to cover the additional costs of the catastrophic benefit. (In 1988, however, the premium increase would be limited to COLA increases in Social Security benefits). It is estimated that the additional cost of providing catastrophic protection under the Dole plan would be $8.70 per month in 1988.

As with the Administration proposal, the Dole catastrophic benefit is optional only to the extent that Medicare Part B coverage is optional.

Comment:

1. The Dole et al. bill represents a slight improvement over the Administration proposal in that it reduces the number of hospital deductibles for which a beneficiary is liable, reduces the catastrophic cap from $2,000 to $1,800, expands somewhat those items which count toward the cap and improves the home health benefit. But these are marginal improvements.
2. In the absence of special protections for the poor/near-poor, the Dole bill's reliance on a monthly increase of $8.70 may result in some level of beneficiary rejection of Medicare Part B participation.

D. House Ways and Means Proposal (H.R.2470)

Benefit: One of the bills receiving very serious consideration in the Congress is H.R.2470, the catastrophic bill proposed by the House Ways and Means Committee. H.R.2470 is similar in benefit design to the structure of the Administration proposal. It was originally introduced by Representatives Fortney H. (Pete) Stark and Willis D. Gradison as two separate bills known as the "Medicare Parts A and B Catastrophic Protection Acts of 1987."

Under the provisions of H.R.2470, the beneficiary would be entitled to unlimited inpatient hospital days subject to one annual deductible per year, indexed annually to the Social Security COLA. In addition, the hospice benefit would be extended beyond the current 210-day benefit period, if the patient were recertified as still terminally ill at the end of the 210-day period.

H.R.2470 would reduce the SNF coinsurance amount to 20% of the national average of the per diem cost that Medicare has determined to be "reasonable" for SNF services, and transfer such coinsurance to the first seven days of Medicare-covered SNF care. It would also eliminate the three-day prior hospitalization requirement for SNF services (added as an amendment when voted out of the House Ways and

Means Subcommittee on Health), as well as extend Medicare's coverage of SNF services from 100 days to 150 days each year.

Home health care services would be expanded under H.R.2470 to provide up to 35 days of continuous care with physician certification. Daily care would be defined as up to seven days per week for a maximum of 35 days in a particular period rather than five days per week for a maximum of two to three weeks. (This provision was added as an amendment when the bill was voted out of subcommittee). The bill would impose a limit or catastrophic "cap" on Medicare Part B deductible and coinsurance liability, set at $1,000 in 1988 and indexed to the Social Security COLA in succeeding years.

The current maximum Medicare reimbursement for outpatient mental health services would be increased from $250 to $1,000 per calendar year. (This benefit expansion was added by amendment to the original bills). Beneficiaries would be permitted to count up to $250 in reimbursable mental health services toward the catastrophic cap.

Finally, the Ways and Means bill, when voted out of subcommittee, was amended to establish a separate category of elderly and disabled persons for whom state Medicaid programs would be required to pay Medicare premiums, deductibles, and coinsurance amounts. Individuals at or below the federal poverty level would qualify for this benefit.

Financing: The benefit improvements incorporated in H.R.2470 were originally financed through two mechanisms. The first of these would have taxed the actuarial value of both the Medicare Part A benefit and the Medicare Part B benefit. An individual's gross income subject to taxation would have included, then, the subsidized portion (or 50%) of the actuarial value of Medicare Part A and the subsidized portion (or 75%) of the actuarial value of Medicare Part B. In 1988, the total subsidized portion of the Medicare benefit was projected to be $1,776. Medicare beneficiaries in the 15% tax bracket would have experienced a $266 dollar increase in tax liability in 1988; those in the 28% bracket would have paid an additional $497. [40]

To keep premium payments at 25% of Medicare Part B costs, the monthly Medicare Part B premium in the original bill would have also increased by $1.30 in 1988. This increase would have been over and above the increase in the Part B premium already scheduled for 1988 under current law. (The premium adjustment discussed here was added by amendment when the original bill was voted out of subcommittee).

When the House Ways and Means proposal was approved in full committee, it replaced the original financing mechanism described above with a dual catastrophic premium approach. Under this arrangement, all Medicare beneficiaries would pay an additional "basic" premium of $1.00 per month beginning in 1990 (rising to $1.50 in 1991), over and above the existing Part B premium.

Those tax-filing Medicare beneficiaries with adjusted gross income (AGI) above $6,000 would also pay a "supplemental" catastrophic premium which would be phased in according to income. In 1988, the supplemental premium would be calculated at $10.00 per year for every $143 in AGI over $6,000. The supplemental premium would be capped at $580 for singles and $1,160 for married couples in 1988. Single individuals would hit the cap at about $14,000 in AGI (or at about $19,000 in total income); married couples would do so at about $28,000 in AGI (or at about $38,000 in total income). [Note: Premium amounts discussed here could change, should the Committee act to include a prescription drug benefit in its package.]

The "basic" catastrophic premium would be indexed along with the Part B premium already in place. The supplemental premium would be indexed to annual increases in the value of the total subsidized portions of Medicare Parts A and B.

Under the H.R.2470 plan, enrollees could reject Medicare Part B coverage, thereby avoiding liability for the basic Part B premiums. However, the supplemental premium would be mandatory for virtually all individuals eligible under Medicare Part A (assuming they are tax filers).

Comment:

1. The House Ways and Means bill at this writing contains a number of improvements in benefit design over the Administration's proposal. The

limitation of hospital deductibles to one is an important addition to the benefit package, as it means no increased aggregate hospital deductible liability.

2. Further, the use of a $1,000 Part B cap on coinsurance and deductible liability is superior to the Administration's Part A/Part B combined cap, since it facilitates triggering the cap at an earlier point. Nevertheless, although probably two million enrollees will trigger the $1,000 cap on Part B covered-service liability, again, 80% of these will already be protected for such liability by Medigap and/or Medicaid coverage.

   The remaining 20% or 400,000 individuals (half of whom are poor or near-poor) may find that they have already hit catastrophic levels of expenditure before they trigger their catastrophic protection. Their actual annual expenditures for health care may total $1,500 to $2,000 ($1,000 for covered-service liability plus another $500 to $1,000 in expenditures for items not counting toward the cap).

3. The inclusion of enhanced Medicaid protections for the poor, expanded home health benefits, expanded hospice benefits, the elimination of the three-day prior hospitalization requirement for SNF care, and expanded mental health benefits all represent important improvements in the Medicare program. The transfer of the SNF coinsurance requirements to the first seven days of SNF care from days 21 through 100 is more generous than current law liability, but, of course, is not nearly as generous as recommendations by the Administration and Dole et al., to eliminate the SNF coinsurance requirement altogether.

   The extension of Medicare coverage of the SNF benefit from 100 days to 150 days represents very slight improvement, given the insignificant numbers of enrollees currently using 100 days or more of covered SNF care. (The average Medicare-covered SNF stay is currently around 28 days; were limitations on access to the SNF benefit relaxed, the extension of potential coverage from 100 to 150 days could be meaningful).

4. The financing mechanism originally proposed by Representatives Stark and Gradison in subcommittee, i.e., taxing the actuarial value of the Medicare benefit, represented a radical -- and, in many ways, troubling -- departure from existing financing mechanisms for the Medicare program. Such an approach would have: (a) set an undesirable precedent in the taxation of "in kind" benefits; (b) imposed a significant tax burden on single retirees, especially those with $10,000 to $15,000 in annual income; (c) increased state tax liability of beneficiaries in more than half the states; and (d) increased tax liability for 45% of tax-paying older Americans, and added close to two million lower-income elderly persons to the tax rolls.

Clearly, the revised financing mechanism of the House Ways and Means bill represents a desirable movement away from the Committee's original troubling proposal to tax the actuarial value of the Medicare benefit. It is, of course, a more progressive approach than the existing Medicare financing mechanism as it links the supplemental premium to tax status.

At this writing, for example, it appears that elderly individuals with less than $6,000 in AGI (or, when Social Security is taken into account, less than $11,000 in total income) and elderly married couples with less than $12,000 in AGI (or less than $22,000 in total income) will be unaffected by the plan's supplemental catastrophic premium, although they will be liable for the additional "basic" premium. The latter has, of course, has been kept low (i.e., $1.00 per month in 1990, $1.50 per month in 1991, and indexed thereafter with the current Part B premium).

While the House bill does not appear to place a heavy burden on low-income beneficiaries, the supplemental premium, once triggered at about $6,000 AGI for singles ($12,000 for married couples), phases in very steeply. It is fully phased in for singles at about $14,000 AGI

($19,000 total income) and for married couples at about $28,000 AGI ($38,000 total income). The maximum amount that beneficiaries would pay in additional catastrophic premiums each year would be $580 for singles and $1,160 for married couples.

Given the bill's early full phase-in, then, singles with AGI over $14,000 would all be subject to the same annual maximum catastrophic premium amount of $580, regardless of whether their income were $15,000 or $50,000. Similarly, all married couples with AGI in excess of $28,000 would be equally liable for the maximum catastrophic premium payment of $1,160, whether their AGI were $29,000 or $100,000.

E. Senate Finance Proposal (S.1127)

Benefit: Another catastrophic bill receiving very serious attention in the Congress is S.1127, the Senate Finance Committee's proposal. Like the House Ways and Means proposal, the Senate plan would eliminate all hospital coinsurance and lifetime limits on inpatient days, subject to a single annual deductible. It would also eliminate the 210-day limit on hospice coverage.

In addition, the Senate plan would further reduce the SNF coinsurance to an amount equal to 15% of the national average Medicare SNF cost per day, and impose the SNF coinsurance for the first 10 days of a covered SNF stay. Like the House plan, it would extend Medicare coverage of SNF services from 100 days to 150 days per benefit period.

S.1127 would also increase the number of days for which a beneficiary could receive daily home health care from 21 to 45 if the need for such services occurred in conjunction with a recent hospitalization or a SNF stay. It also would entitle the beneficiary to a maximum of 21 days of daily care, whether or not he had been recently hospitalized or confined to SNF.

The Senate plan's annual catastrophic cap would be set at $1,700 and indexed to the Social Security COLA. Beneficiary liability for coinsurance and deductibles under both Medicare A and B would count toward the cap, as would beneficiary costs for immuno-suppressive drugs.

The plan also would require that the HHS Secretary estimate savings to each state Medicaid program deriving from Medicare's expanded benefits, and that such savings be used to expand coverage of Medicare beneficiaries with low incomes or to support spousal impoverishment remedies.

Finally, the Senate proposal, like the earlier Dole et al. bill, calls for studies by the Institute of Medicine on: (1) the expansion of Medicare to include prescription drug coverage; and (2) public and private options for financing long-term care.

Financing: The catastrophic benefits of the Senate Finance bill would be financed through a double premium approach that is similar in structure to the financing mechanism included in the House Ways and Means bill. All beneficiaries electing Medicare Part B coverage would be automatically enrolled in the catastrophic coverage program; all would pay an additional "basic" premium of $4.00 per month in 1988, indexed to increases in the cost of the catastrophic benefit. This increase would be in addition to increases in the Part B premium already scheduled for 1988.

Additionally, Medicare Part B enrollees would be required to pay a "supplemental premium" based on the amount of income tax each pays. The supplemental premium would be equal to $13.50 per year for each $150 of income tax due after the first $150 of tax liability; the supplemental premium would be capped at $840 for singles and $1,680 for married couples in 1988. The annual limit on the supplemental premium would rise to $1,000 in 1992. Thereafter, it would be indexed to increases in the subsidized portion of Medicare Part B.

Single individuals under this plan would hit the cap at about $50,000 in AGI, while married couples would do so at about $95,000 in AGI.

Under S.1127, both the basic and the supplemental premiums would be optional, that is, they would be applicable only if the enrollee elected Medicare Part B coverage. While all Part B enrollees would pay the $4.00 basic monthly premium for catastrophic coverage, it is projected that less than one-half would be required to pay the "supplemental" catastrophic premium.

Comment:

1. The Senate Finance proposal shares many of the benefit improvement features of the House Ways and Means bill. However, at $1,700 annually its catastrophic cap is slightly less generous than the cap proposed by the House. It also has a slightly less generous SNF benefit, and a somewhat different home health care benefit from that proposed by the House. Like the House bill, S.1127 also provides some enhanced Medicaid protection to low-income elderly.

2. While the Senate Finance bill incorporates a dual-premium financing mechanism similar to that contained in the House Ways and Means catastrophic bill, the Senate approach differs from the House approach in several significant ways. These differences are shown below.

Table 3

	H.R.2470	S.1127
Supplemental Premium		
Applies to:	Tax Filers	Taxpayers
For Singles (1988):	Min: $10 at $6000 AGI Max: $580 at $14,166 AGI	$13.50 at $7,750 AGI $840 at $50,000 AGI
For Married Couples (1988):	Min: $20 at $12,000 AGI Max: $1,160 at $28,332 AGI [Note: Each member of the couple pays a supplemental premium].	$13.50 at $12,100 AGI $1,680 at $95,000 AGI [Note: Couple pays only one supplemental premium].
Rate of Phase-in:	$1/$14.30 of income	$1/$74.07 of income
Deductibility:	Not deductible as a medical expense.	Deductible as a medical expense.
"Basic" Premium		
Applies to:	Each Beneficiary	Each Beneficiary
Premium Amount:	$0/Month in 1988 and 1989 $1/Month in 1990	$4/Month in 1988

The Senate bill distributes the supplemental premium across a much broader income range than does the House bill, with the supplemental premium increasing as income rises, up to $50,000 in AGI for singles and $95,000 in AGI for married couples. As indicated by Charts 9 and 10, the Senate bill is closer in structure to a surtax, while the House bill, incorporates essentially two supplemental premium levels linked by a steep phase-in.

F. Pepper Proposal (H.R.65)

Benefit: The Pepper proposal differs significantly from all of the foregoing plans in benefit design, scope of coverage and delivery mechanism. Through the creation of a mandatory Medicare Part C program, beneficiaries would receive a vastly expanded array of covered services and products, including: unlimited inpatient hospital care; routine dental care, hearing care (including hearing aids), vision care (including eyeglasses), and podiatric care; prescription drugs; preventive care (i.e., physical examinations, pap smears, mammograms, etc.); and long-term care services, both institutional and home-and community-based.

Beneficiaries would pay neither deductibles nor coinsurance for the new set of comprehensive services, but the services would be provided through eligible organizations under contract with Medicare. In return for providing the full range of services, the contract organization (whether an HMO, PPO, doctors' group, or insurance company) would be reimbursed a fixed capitated rate per beneficiary based on the cost to Medicare of providing care to the average beneficiary in a given area.

Financing: Revenues to finance the full Medicare package outlined in H.R.65 would come from a variety of sources:

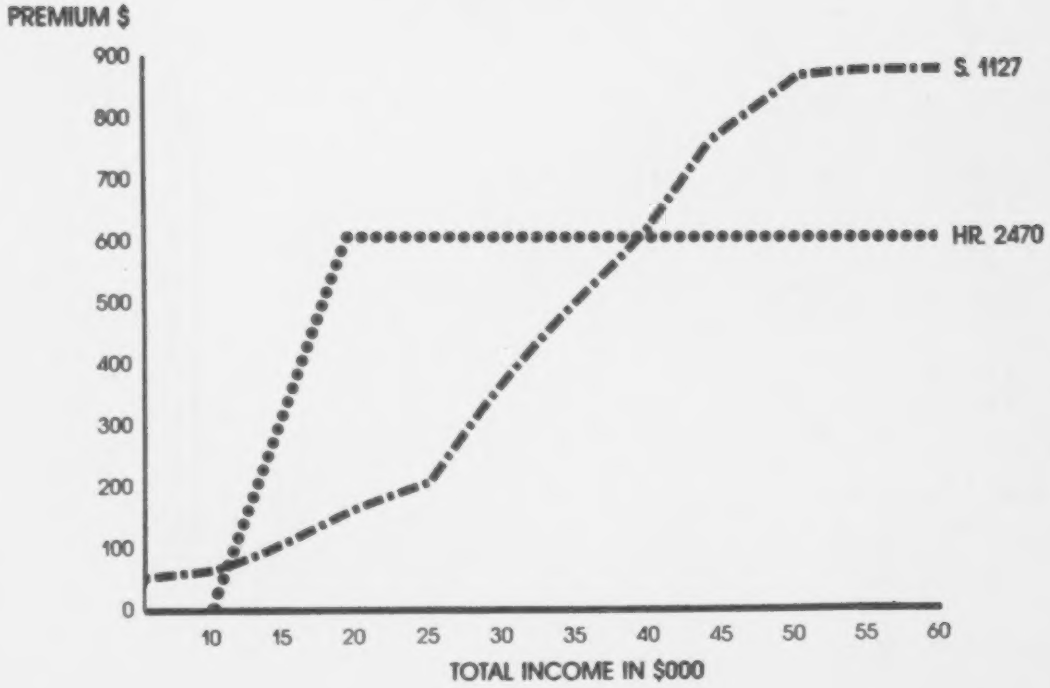
1. Existing Medicare A & B revenues;

2. Existing Medicare Part B premium income (the 1987 monthly premium is $17.90);

3. An additional premium equal to $50 per month or $600 per year. (Congressman Pepper anticipates that, given the

COST OF HR. 2470 & S. 1127
SINGLE ENROLLEE, 1988

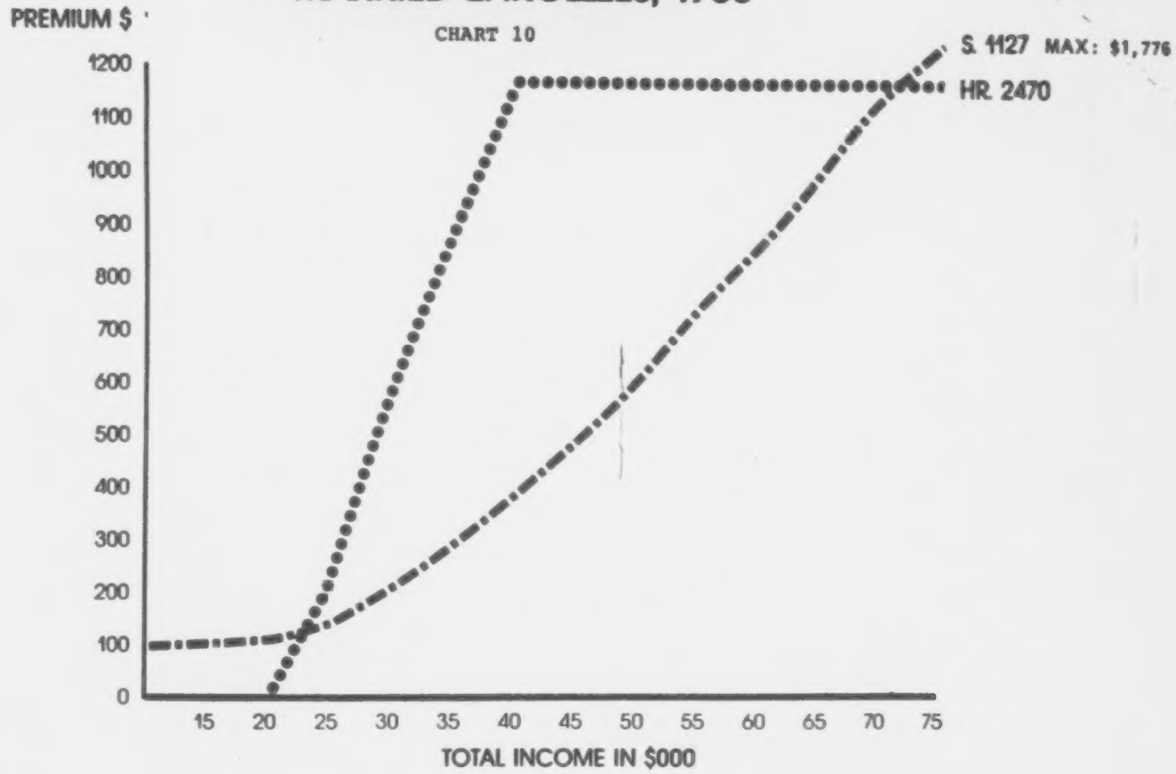
CHART 9



Source: AARP

COST OF HR. 2470 & S. 1127
MARRIED ENROLLEES, 1988

CHART 10



Source: AARP

comprehensive nature of the coverage under H.R.65, beneficiaries could -- and would -- drop their present Medigap coverage, the savings from which disenrollment could then be used to partially defray the costs of the Medicare Part C program). The combined premiums, totalling approximately $800 per year, would in no instance exceed 10% of annual AGI;

4. Repeal of the limits on that portion of earned income subject to the Medicare payroll tax for those earning in excess of $44,000 per year;

5. State and federal Medicaid payments for services to the elderly and disabled to be covered under the proposed Medicare Part C program. States would be required to pay for the cost of enrolling Medicaid-eligible beneficiaries at a rate equal to 90% of the states' projected average Medicaid payments for these individuals in the following years.

Comment:

1. The benefit package of the Pepper bill represents a major expansion of Medicare-covered services. Such a package, incorporating as it does long-term care services, prescription drugs, home health care, preventive services, dental care, visual care, etc., could eliminate the need for Medigap coverage. Indeed, the plan's financing mechanism depends in large part upon such expected beneficiary behavior.

2. The size of the Medicare premium is not, however, insignificant, especially for the very poor, who might encounter difficulty in paying a premium of $600 per year on a $6,000 annual income. It could also be burdensome for those who are not presently able to afford Medigap coverage.

   In addition, the Congressional Budget Office has not yet verified the amount of revenue which the Pepper bill claims can be achieved by lifting the limit on earned income subject to Medicare taxation.

3. Questions have been raised about the Pepper bill's commitment to major changes in the way in which services would be delivered to Medicare beneficiaries under the terms of H.R.65. It may be premature to adopt a fully capitated approach to Medicare service delivery in the absence of evidence that such an approach can yield savings without sacrificing either quality of care or consumer choice.

NOTE: The House Energy and Commerce Committee, which shares jurisdiction over Medicare Part B with the House Ways and Means Committee, has not at this writing completed action on a catastrophic benefit. It is expected that the Energy and Commerce Committee could make significant improvements in the areas of out-patient prescription drug coverage, spousal impoverishment, and respite care.

VII. AARP'S CATASTROPHIC RECOMMENDATIONS

AARP has structured its catastrophic recommendations to reflect the conviction that proposals laying claim to the provision of any level of catastrophic protection must identify and appropriately address actual sources of vulnerability. While recognizing that long-term care is, of course, the real source of catastrophic costs for older Americans, AARP has also noted that acute care and transitional care expenditures -- for both coinsurance and deductible requirements as well as non-covered services and goods -- can threaten the financial security of many older Americans. In fact, such expenditures can be devastating to low-income elderly.

Given these concerns, the Association advocates the development of a benefit improvement that incorporates a catastrophic cap but is more comprehensive than most other catastrophic proposals under serious consideration. The AARP recommendations are intended to better balance the need for acute, transitional, and long-term care catastrophic protection while at the same time providing critical protections for low-income elderly people.

Benefit: 1. Acute Care

- Unlimited inpatient hospital care subject to one annual hospital deductible each year;
- Elimination of SNF coinsurance;
- Elimination of the three-day prior hospitalization requirement for SNF eligibility;
- Addition of an outpatient prescription drug benefit with a $500 annual deductible and a 20% copayment. The latter would count toward the recommended catastrophic cap;
- Improvement in the Medicaid program through the establishment of a uniform mandatory income standard for Medicaid eligibility at 65% of federal poverty level and the expansion of the Medicaid "buy-in" of Medicare services for eligible recipients with income at or below 100% of the federal poverty

level. (The Association views these provisions as inseparable from the cap which, at $1,000, is too high to adequately protect low-income beneficiaries.)

2. Transitional Care

   - o Addition of an expanded home health care benefit to provide up to 42 days of continuous home health care for eligible beneficiaries.

   - o Addition of a maximum of 120 hours of respite care each year with eligibility for such care based on limitations in Activities of Daily Living (ADLs).

3. Long-term Care

   - o Establishment of a standard minimum income disregard for the non-institutionalized spouse;

   - o Authorization to the states to add home and community-based care as an optional service under Medicaid in lieu of waiver compliance.

Financing:

1. Increase in the Part B premium not to exceed $10.00 per month;
2. Extension of Medicare taxation to all state and local employees;
3. Doubling of the cigarette tax.

VIII. LOOMING CATASTROPHIC ILLNESS ISSUES: LONG-TERM CARE AND HEALTH CARE FOR THE UNINSURED

While long-term care financing and catastrophic protections for the uninsured lie outside the scope of this paper, they represent areas of concern that must be addressed effectively -- and soon -- by this country. The challenges they represent are not the responsibility of the health care system, but rather the responsibility of society.

A. Long-term Care

By far the most critical catastrophic health care expense to older Americans is that of long-term, chronic illness. Nursing home stays account for over 80% of the expenses incurred by older persons who experience very high out-of-pocket costs for health care, i.e. over $2,000 per year (Chart 11). [41] The need for long-term care leads almost inevitably to an unmanageable financial burden because the costs of care -- be it in an institution or in the home -- are often enormous. The cost of care in a nursing home now averages nationally over $20,000 per year, and the cost of home care can range from $50 to $200 per day.

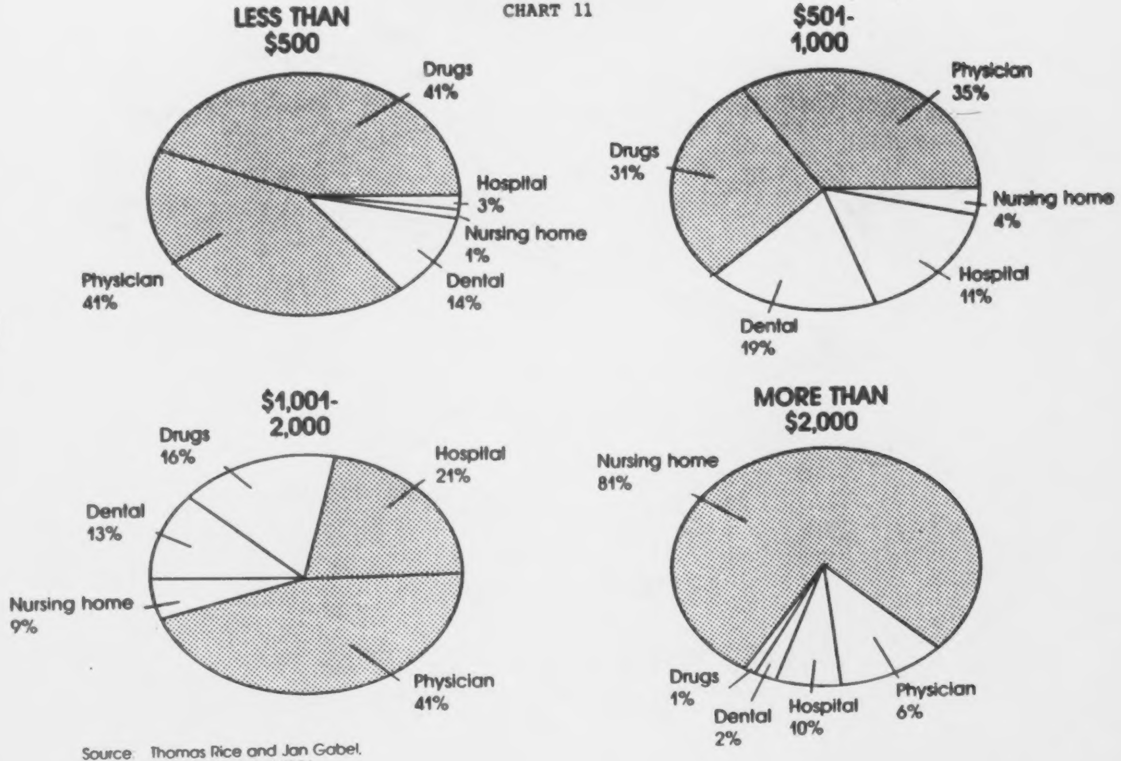
In 1985, a total of $35.2 billion was spent on nursing home care. As indicated on Chart 12, the majority (51.4%) of this amount was paid out-of-pocket by older persons or their families. Medicare and private insurance combined paid only 2.7% of all nursing home costs. The major government payor for nursing home care is Medicaid (41.8%). To qualify for Medicaid, one must either be poor or reduced to poverty in the process of paying for care.

Few people can afford the expense of an extended nursing home stay, so many eventually end up on Medicaid, but only after financial catastrophe has occurred. Almost one-half of Medicaid dollars for nursing home care for the elderly is spent on behalf of persons who enter nursing homes as private paying residents. [42] The process of "spending-down" one's income and depleting one's assets to qualify for Medicaid can occur very quickly. A 1985 study conducted for the House Aging Committee found that approximately two-thirds of single older persons and one-third of couples in Massachusetts were impoverished after only 13 weeks in a nursing home. [43]

As such statistics indicate, the impoverishment of a spouse in the community in order to finance the care of an institutionalized mate is one of the most serious problems facing older couples today. To be eligible for Medicaid, couples must

OUT-OF-POCKET COSTS BY TYPE OF SERVICE (1980)

CHART 11

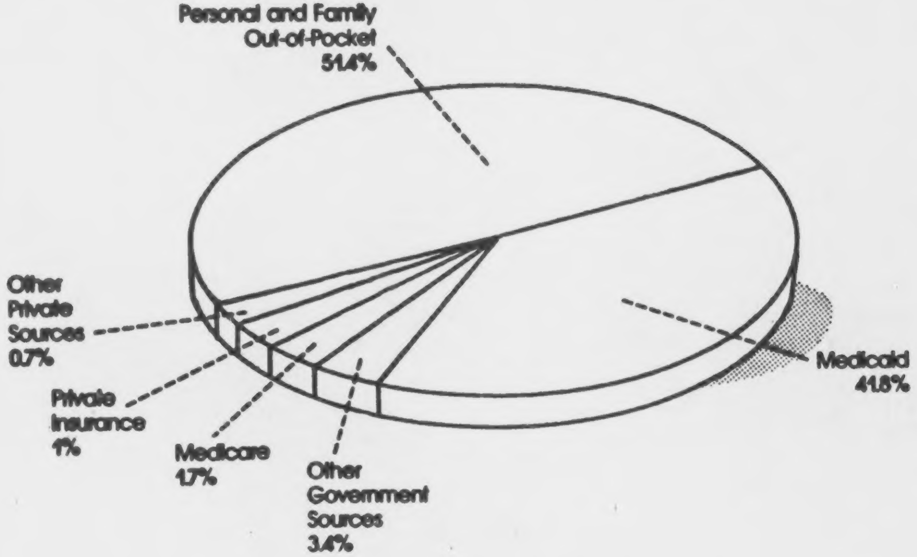


Source: Thomas Rice and Jan Gabel, *Health Affairs*, Fall 1986.

NURSING HOME COSTS BY SOURCE OF PAYMENT, 1985

(A TOTAL OF $35.2 BILLION)

CHART 12



Source: Health Care Financing Administration, Office of the Actuary often spend down their combined income and assets, leaving one spouse - usually the wife - destitute. Many of the same women who are caught in the spend down problem have spent years taking care of ill and disabled husbands at home.

Not only are older persons and their families now paying more than half of all nursing home expenses, but the proportion of total nursing home costs paid out-of-pocket has been increasing, i.e., by about 20% from 1975 to 1985 (Chart 13). During the same time period, the proportion of nursing home costs financed by Medicaid decreased. [44] The rapid growth in payments for nursing home care by Medicaid, which increased by 306% between 1975 and 1985, has received a good deal of policy attention. Less frequently pointed out is that private out-of-pocket payments, which rose 420% in the same period, have increased even more dramatically.

The vast majority (71%) of long-term care is provided in the community rather than in institutions, and families are the bulwark of the long-term care delivery system. As illustrated on Chart 14, almost three out of four functionally impaired older Americans rely exclusively on unpaid care provided by families or friends, and another 21% on a combination of support from families and paid providers. Only 5% of the functionally impaired elderly rely solely on paid providers.

Of paid long-term care in the community, only 25% is financed by government sources. [45] Since paid care represents only a small proportion of the total long-term care being provided, older persons or their families are bearing over 90% of the direct or indirect costs of care in the community (Chart 14). This should not be surprising since personal care services in the home of indefinite duration are not covered at all by Medicare. The amount and type of home care provided under Medicaid is extremely limited in most states, and private insurance protection is minimal.

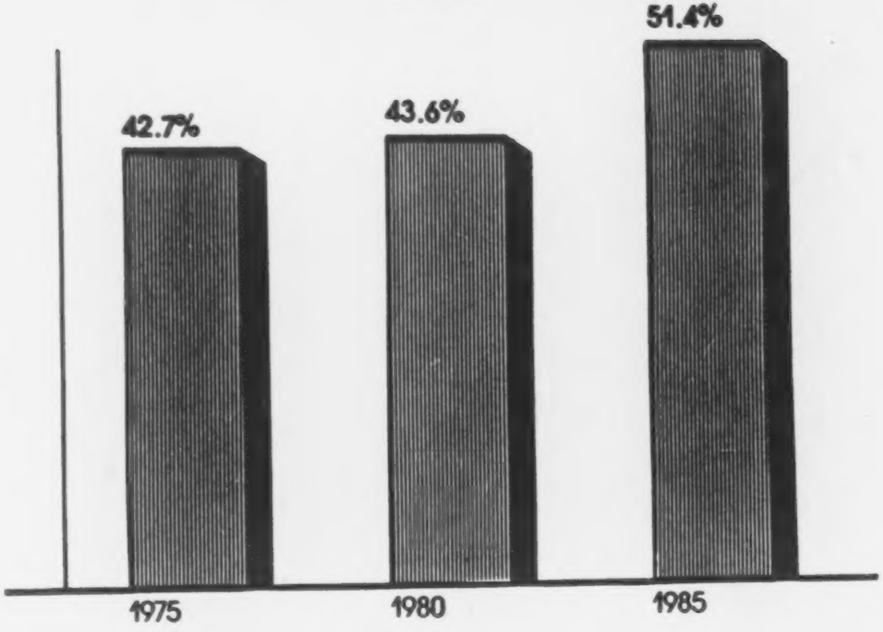
B. Health Care for the Uninsured

The need for catastrophic health protection also extends to persons under age 65, although the problems for this population differ somewhat from those facing older Americans. Here the issues center on the more than 35 million individuals under the age of 65 who lack any type of health insurance, either public or private. For such younger adults and children, even a simple visit to the hospital can result in catastrophically high medical bills. In addition, many other families have inadequate health insurance protection that leaves them vulnerable to high out-of-pocket costs in much the same way that Medicare fails to offer true catastrophic protection.

OUT-OF-POCKET PAYMENTS FOR NURSING HOME CARE 1975–1985

(AS % OF TOTAL NURSING HOME EXPENDITURES)

CHART 13

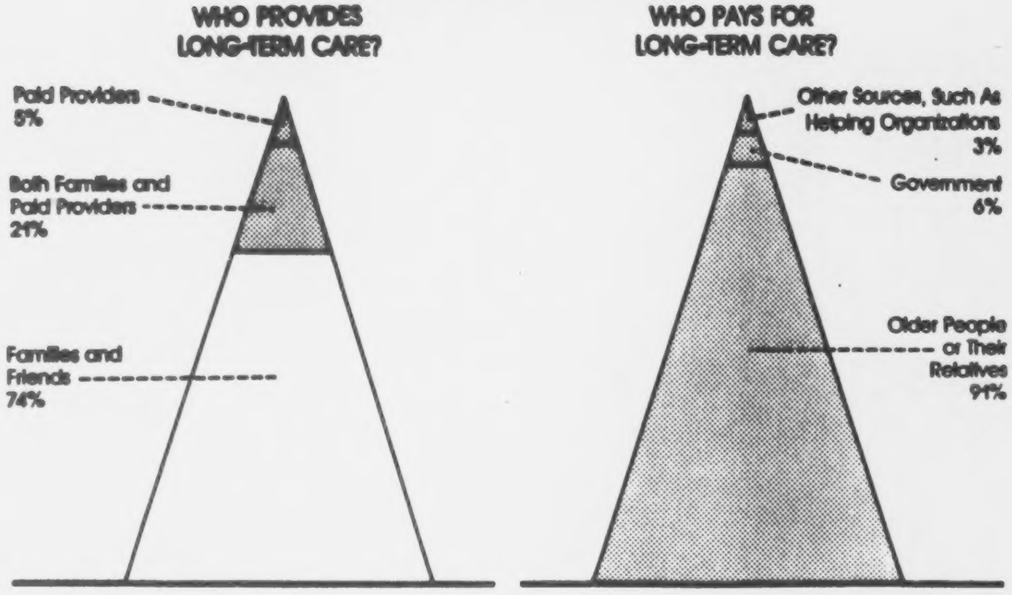


Source: Health Care Financing Administration, Office of the Actuary

LONG-TERM CARE IN THE COMMUNITY

(71% OF ALL LONG-TERM CARE)

CHART 14



Source: 1982 National Long Term Care Survey

The numbers of people without health insurance have increased steadily in the 1980s, rising initially with the recession early in this decade but continuing to increase even after the recovery began. This problem, then, is not merely one of unemployment; indeed, nearly 13.5% of all employed adults lack health insurance. Persons with low incomes, of course, are particularly at risk. More than one-third of the uninsured live in families with incomes below the poverty line.

And perhaps most troubling of all are the numbers of children without insurance. Nearly 12 million children under the age of 18 lacked health insurance in 1984. In other words, nearly one in every six children in the United States had no protection against high health care costs. [46]

IX. GUIDELINES FOR POLICY EVALUATION/DEVELOPMENT

The foregoing discussion of the catastrophic illness experience among older Americans offers suggestions for the evaluation of catastrophic plans that have been proposed as well as for the development of new, more effective plans. Below follows a brief review of the implications of the elderly catastrophic illness experience for the development of public policy.

1. Addressing the Right Problem

   It is imperative that proposals purporting to deal with catastrophic illness costs focus on the "true" problem. In the case of older Americans, that problem derives from the cost of long-term care. Plans which tackle acute care catastrophic costs for older Americans may ultimately yield an improved Medicare program, but they have not necessarily provided catastrophic "protection" and peace of mind to older Americans. This is not merely a matter of semantics; it is not conscionable to characterize an expanded Medicare package as "catastrophic" if it fails to address the single greatest source of catastrophic costs for the elderly -- long-term care.

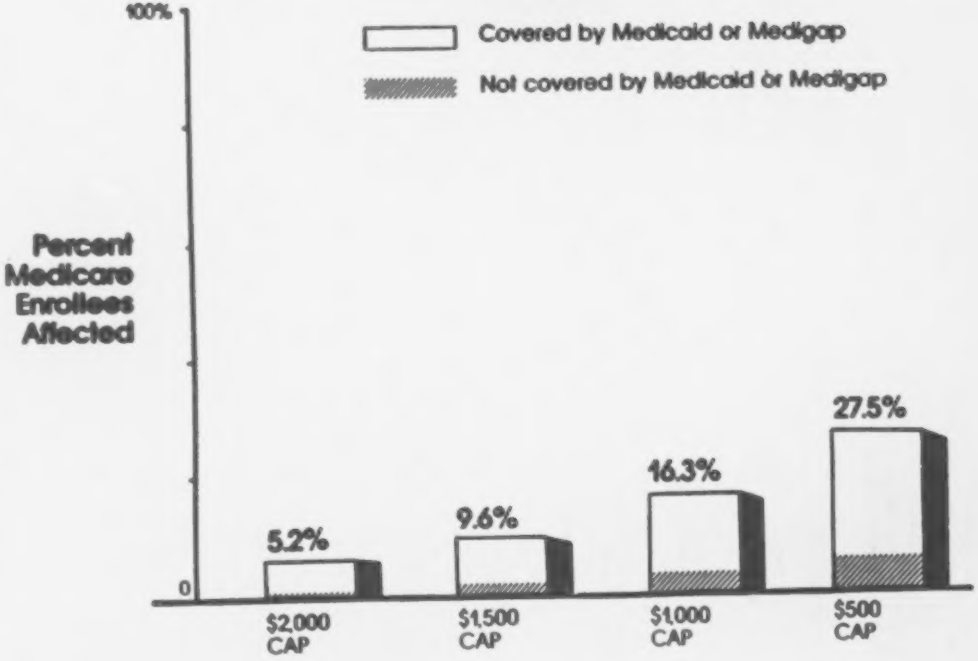
2. The "Cap" Dilemma

   There is something almost seductively appealing about a catastrophic cap. It has the ring of certitude -- predictable fixed limits on expenditures and predictable security. But one of the dilemmas policymakers face in attempting to set a protective cap on catastrophic costs is pinpointing the appropriate level for such a cap.

   Set the cap high, and the benefit can be financed without great difficulty; but as is clear from Chart 15, few are protected under such an arrangement. As one pushes the cap down, the protective scope of the cap expands but the cost rises proportionately. Severely restrict the elements of liability which count toward the cap, and the plan becomes more affordable; the danger in this arrangement, of course, is that beneficiaries may wrongly assume that their total out-of-pocket liability in a given year will not exceed the cap level. As they gradually come to realize that a full range of

CATASTROPHIC CAPS: WHO BENEFITS? (1988)

CHART 15



Source: CBO Estimates

essential medical services and products do not even count toward the "catastrophic" cap, they are apt to feel disappointed, if not duped.

3. The Cumulative Nature of the Acute Care Catastrophe

In dealing with potentially catastrophic acute care health costs for older Americans, it is important to acknowledge the cumulative nature of the acute care catastrophic experience. It is rarely the case that hospital care alone generates catastrophic medical bills, nor that prescription drug costs alone do so, nor that balance billing by physicians, or dental care or visual care individually do so. Rather, the acute care catastrophic experience among older people depends for its impact upon the accumulation of a variety of acute care services and products. Catastrophic proposals must accommodate the multi-faceted character of the acute care catastrophic phenomenon.

4. Targeting the Right Population

Special protections must be provided the poor and the near-poor elderly. As indicated earlier, fully 80% of Medicare beneficiaries are additionally protected by Medigap and/or Medicaid coverage. Their protections against coinsurance and deductible liability for Medicare-covered services is considerable. Of the remaining 20%, however, half or 10% are poor/near-poor, old, and frail; they deserve special attention, for they are the elderly subgroup most vulnerable to acute care catastrophic health care costs.

The time has come, clearly, to address the catastrophic illness problem for older Americans. Policymakers have a moral, if not a practical or political imperative, to identify correctly the catastrophic issue for those over the age of 65, and to target remedies on those most in need. Diffused solutions attempting to remedy all deficient aspects of health care coverage and delivery for the elderly are not necessarily useful. Attractive as they may appear, they tend to dissipate scarce resources, create a false sense of security among those who stand to gain or lose the most from public policy decisions on the catastrophic illness issue, and deprive those most in need of real protections.

REFERENCES

1. Gordon R. Trapnell, James W. Mays, and Inger M. Tallis, Strategies for Insuring Catastrophic Illness: Financial Burden, Prototype Plans, and Cost Estimates. Hoffman-LaRoche, Inc., 1983, p.2.

2. Leon Wyszewianski, "Financially Catastrophic and High-Cost Cases: Definitions, Distinctions, and Their Implications for Policy Formulation," Inquiry, Vol. 23 (Winter 1986), 382-384.

3. S.E. Berki, "A Look at Catastrophic Medical Expenses and the Poor," Health Affairs, Vol. 5 (Winter 1986), 138-144.

4. Health Care Financing Administration, Office of the Actuary. Part A data were supplied by Claire Albrecht, and Part B data by Deborah Cheney. Totals represent actual, cash (not incurred) costs for calendar years 1984 and 1986. While totals are actual figures, the break-out data shown here are estimates, subject to revision by the Office of the Actuary, May 13-14, 1987.

5. Health Care Financing Administration, Office of the Actuary, data were supplied by Chris Howe, May 13, 1987.

6. Judith Feder, Center for Health Policy Studies, Georgetown University School of Medicine, Testimony before the Subcommittee on Health, Committee on Ways and Means, U.S. House of Representatives, March 4, 1987.

7. Health Care Financing Administration, Office of Research and Demonstrations, data supplied by Marian Gornick, Spring 1986.

8. Health Care Financing Administration, Office of the Actuary (Medicare Part A), Spring 1987.

9. Health Care Financing Administration, Office of the Actuary (Medicare Part A), data supplied by Ken Leong, Spring 1987.

10. Health Care Financing Administration, Office of the Actuary (Medicare Part B), data supplied by Deborah Cheney, January 1987.

11. Health Care Financing Administration, Office of Research and Demonstrations, based on figures supplied by Alma McMillan, Fall 1987.

12. "Prescribed Medicines: Use, Expenditures, and Sources of Payment," NCHSR, National Health Care Expenditures Survey, Data Preview 9, April 1982, Table 1.

13. AARP Seventh Annual Survey of Older Americans, November 1985, and AARP Eighth Annual Survey of Older Americans, December 1986, Hamilton and Staff, Washington, D.C.

14. Judith Brown, "Prescription Drug Costs for Older Americans," AARP Issue Brief, March 1987.

15. Health Care Financing Administration, data supplied by Charlie Waldhauser, January 1987.

16. Health Care Financing Administration, data supplied by Edna Ross, Office of Information Services, January 1987.

17. Alma McMillan, James Lubitz, and Marilyn Newton, "Trends in Physician Assignment Rates for Medicare Services, 1968-1984," Health Care Financing Review, Vol. 7, No. 2, Winter 1985, p. 69.

18. McMillan, Lubitz, and Newton, Tables 4 & 7.

19. Health Care Financing Administration, Office of Information Services, data supplied by Edna Ross, Fall 1986.

20. Ibid.

21. Health Care Financing Administration, data supplied by Charlie Waldhauser, Fall 1986.

22. Ibid.

23. The Role of Medicare in Financing the Health Care of Older Americans, report prepared for AARP by ICF Incorporated, July 1985, Table 8.

24. "Private Health Insurance Coverage of the Medicare Population," NCHSR, National Health Care Expenditures Survey, Data Preview 18, September 1984, pp. 22-23.

25. Ibid.

26. Ibid.

27. Ibid.

28. "Medigap Insurance: Law Has Increased Protection Against Substandard and Overpriced Policies," GAO Report, October 1986, Executive Summary, p. 3.

29. "Supplemental Health Insurance Coverage Among Aged Medicare Beneficiaries," National Center for Health Statistics, Series B, Descriptive Report No. 5, August 1985, p. 10.

30. The Effects of Variations in Medicaid Programs on Older Women, report prepared by ICF Incorporated for AARP, December 1986, Figure 4. (ICF derived Figure 4 from 1984 CBO Table).

31. Alma McMillan and Marian Gornick, "The Dually Entitled Elderly Medicare and Medicaid Population Living in the Community," Health Care Financing Review, Vol. 6, No. 2 (Winter 1984), 75-76.

32. McMillan and Gornick, 76.

33. McMillan and Gornick, Table 10, p. 81.

34. Ibid.

35. Ibid.

36. Ibid.

37. Gail Lee Cafferata and Mark R. Meiners, "Public and Private Insurance and the Medicare Population's Out-of-Pocket Expenditures: Does Medigap Make a Difference?," Draft Report, National Center for Health Services Research, May 1985, 4-5.

38. The Effects of Variations in Medicaid Programs on Older Women, Figure 4.

39. Congressional Budget Office (CBO) Memorandum from Sandra Christensen regarding "Background on Out-of-Pocket Costs for Medicare Enrollees," January 16, 1987, p. 2.

40. In 1988, single individuals in the 15% tax bracket have AGIs between $5,750 and $23,600; married couples in the 15% tax bracket have AGIs between $10,100 and $39,850. The 28% tax bracket includes singles with $23,600 or more in AGI, and married couples with $39,850 or more in AGI.

41. Thomas Rice and Jon Gabel, "Protecting the Elderly Against High Health Care Costs," Health Affairs (Fall 1986), Exhibit 6, p. 16.

42. McMillan and Gornick, "The Dually Entitled Medicare and Medicaid Population Living in the Community," p. 73.

43. "America's Elderly Are At Risk," report published by the Select Committee on Aging, House of Representatives, 99th Congress, First Session, July 1985.

44. Daniel Waldo, Katherine R. Levit, and Helen Lazenby, "National Health Expenditures, 1985," Health Care Financing Review, Vol. 8, No. 1 (Fall 1986), Table 7, p. 17.

45. Korbin Liu, Kenneth G. Manton, and Barbara Marzetti Liu, "Home Care Expenses for the Disabled Elderly," Health Care Financing Review, Vol. 7, #2 (Winter 1985), pp. 51-53.

46. Margaret B. Sulvetta and Katherine Swartz, The Uninsured and Uncompensated Care: A Chartbook, National Health Policy Forum, George Washington University, June 1986.

LEGAL SERVICES OF MIDDLE TENNESSEE, INC.
800 Stahlman Building
211 Union Street, Nashville, Tennessee 37201 (615) 244-6610

Winter 1987

Dear Sir or Madam:

Legal Services of Middle Tennessee gives certain kinds of free legal help to low-income people and those over age 60. We wrote this book as a community education service for people on Medicare.

Be sure to look at page 1 for a summary of the subjects covered in each chapter of the book. If you want to find information on a specific Medicare Supplement Iinsurance policy, turn to Appendix II on page 109 to see if the insurance company is mentioned in the book.

Effective January 1, 1987, the cost of Medicare Part B coverage went up to $17.90 per month. You will find the 1987 changes in the amount you must pay for hospital and skilled nursing care on an updated page 4 which is on the back of this letter. Those changes also apply to pages 5, 8, 25 and 34. Many insurance companies will probably increase the cost of their policies to cover these changes in Medicare.

If you still have a question about Medicare or health insurance after reading this book, you may write to Legal Services of Middle Tennessee at the address given on the front of your book. Please include your telephone number, as we may need to call you for more information before we can answer your question.

Sincerely,

Adinah Robertson

ASHLEY T. WILTSHIRE
Executive Director

ADINAH ROBERTSON
Community Education Coordinator

P.S.: Before you buy any insurance, please note our advice on page 35 about checking the financial standing of the company. Two Tennessee insurance companies have recently been ordered by the state insurance department to stop selling new policies because of financial problems. They are Continental Banker's Life Insurance Company of the South (on pages 54, 84, 86, 101 and 116) and Hermitage Health and Life Insurance Company (pages 62, 63, 83, 101, and 111). If you are a policyholder with one of these companies you may want to call the state insurance department at (615) 741-7088 for advice.

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SOME OF MEDICARE'S GAPS

SERVICE	Benefit Period	Medicare Pays in 1987	You Are Responsible For
HOSPITALIZATION (Part A): Semi-private room and board Miscellaneous hospital services and supplies, such as: Meals & drugs Special Care Units Diagnostic x-rays Lab tests Operating and recovery rooms	FIRST 60 DAYS	ALL BUT $520	$520
	61st-90th DAYS	ALL BUT $130 A DAY	$130 A DAY
	91st-150th DAYS	ALL BUT $260 A DAY	$260 A DAY
	BEYOND 150 DAYS	NOTHING	100% OF COST
POST-HOSPITAL SKILLED NURSING HOME CARE (SNF CARE) (In a nursing home facility approved by Medicare. You must have been in the hospital for at least 3 days before entering the facility, and care must meet the definition of "skilled nursing care")	FIRST 20 DAYS	100% OF COST	NOTHING
	21st-100th DAYS	ALL BUT $65.00 A DAY	$65.00 A DAY
	BEYOND 100 DAYS	NOTHING	100% OF COST
INTERMEDIATE OR CUSTODIAL CARE in a nursing home		NOTHING	100% OF COST*

*Few Medicare Supplement insurance policies cover intermediate or custodial nursing home care. Medicaid covers intermediate care for people who qualify.

Medicare, Medicaid, and Medicare Supplement Insurance

What You Need To Know To Protect Yourself

Legal Services of Middle Tennessee, Inc.
211 Union Street, Suite 800
Nashville, Tennessee 37201
615-244-6610, 1-800-342-3317

Knoxville Legal Aid Society, Inc.
502 Gay Street, Suite 404
Knoxville, Tennessee 37902

A Community Education Project

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WHAT CAN THIS BOOK DO FOR YOU?

Rather than create a fifth edition of A Guide to the Medicare Supplement Insurance Maze, we have taken a new approach to help you understand Medicare and decide about private insurance to go with Medicare. First, this book expands our previous sections on Medicare to include more tips on saving you money and on protecting your rights. Second, this book explains how Medicaid works with Medicare to pay health care costs for people who have both these kinds of coverage. Third, since an overwhelming number of Medicare Supplement policies--more than 120--are now available for you to choose from, this book is more selective than our previous book in describing specific policies and benefits.

The **table of contents** is detailed, so you can quickly find what you need to know.

In **Chapter 1**, you'll find "the basics" of Medicare. We've added new information on your Medicare rights for those who are worried about being forced to leave the hospital too soon.

Chapter 2 has money-saving advice on Medicare, Medicaid and insurance for persons on limited budgets and for those whose income is moderate or better. It also has a brief discussion of nursing home policies.

Chapter 3 describes your protections under Tennessee's Medicare Supplement insurance law.

Chapter 4 explains the policy benefits we suggest that you look for in a Medicare Supplement insurance policy--"The Big Five" features.

In **Chapter 5** you'll find brief descriptions of 36 Medicare Supplement policies that have "The Big Five" features we recommend.

You can turn to **Chapter 6** for a list of policies that cost less than $500 per year for a 65 year old, but still have two or more of the features we recommend.

Chapter 7 tells you how to use "outlines of coverage" to compare Medicare Supplement policies. It also alerts you to points you should look for in your policy during the "free look" period.

Chapter 8 is written to help those of you who already have health problems when you begin to shop for a Medicare Supplement policy.

Need further help with a problem involving Medicare or insurance? Turn to **Chapter 9** to see if one of the sources of help we list is near you.

Appendix I has "General Insurance Tips," including the toll-free "policyholder service" number at the Tennessee Department of Commerce and Insurance.

Appendix II is an index of insurance companies and of Medicare Supplement policies approved for sale to individuals in Tennessee. This appendix also tells you where to look in this book for information on a particular policy.

Appendix III lists the Medicare-approved ambulatory surgical centers in Tennessee which could save you money.

Appendix IV tells you what prescription drug coverage is available as part of a Medicare Supplement policy.

The **Glossary** gives you the meanings of some of the terms used by Medicare and by insurance companies.

CHAPTER 1: MEDICARE

Do You Need Health Insurance in Addition to Medicare?

You cannot judge your need for additional health insurance unless you understand what your Medicare coverage does and does not do. With this information you can also get the most benefit from your Medicare coverage and take full advantage of insurance policies whose benefits are directly linked to Medicare's coverage and payments.

Medicare is a federally-funded program to help pay health care expenses. It pays for somewhat less than 50% of the health care costs of people over age 65 in this country.

Medicare's coverage is good for some kinds of health care costs, but it is inadequate or non-existent for other kinds. In 1981 Medicare paid for 74% of the overall hospital bills of senior citizens. It paid only 54% of the doctor bills, however, and 2% of nursing home bills. Medicare paid less than 1% of prescription drug costs.*

How adequate Medicare's coverage is for YOU depends on:

-- what health problems you have,

-- whether you have both Parts A and B of Medicare, and

-- what doctors and medical facilities you choose.

Do You Have Both Parts A and B of Medicare?

Medicare is divided into two parts -- Part A or "hospital insurance" and Part B or "medical insurance."

Part A helps pay for hospital stays, care in a skilled nursing facility and part-time skilled care and therapy at home (home health care). Part A coverage is free to persons who qualify for Medicare. It can be bought by others over age 65.

Part B primarily pays toward the costs of doctors' services. There is a monthly charge to have Part B coverage. Most often this charge -- $15.50 a month** -- is deducted from your Social Security check.

Your red, white and blue Medicare card will say "Hospital Insurance" to show that you have Part A. If you have Part B coverage, your card will also say "Medical Insurance."

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* Consumer Reports, June 1984, page 347

** Rate is for January 1986-December 1986.

Who Can Get "Hospital Insurance" ("Part A")

Many people get Part A coverage **free of charge.** They include:

1. People who are age 65 or older and get Social Security benefits,
2. People who get Railroad Retirement benefits,
3. People with certain kidney diseases, and
4. Disabled persons who have been getting Social Security or Railroad Retirement benefits for two years.

Anyone else who is over 65 years of age may **buy** Part A coverage for $214 a month (1986 rate).

Who Can Get "Medical Insurance" ("Part B")

You can enroll in Part B if you are entitled to Part A benefits or have reached age 65. We generally **recommend that you take Part B coverage.** If you do not enroll in Part B when you are first eligible for Medicare, but decide to get it later, you will have to pay a higher monthly premium.

If you get Social Security and decide to take Part B coverage, the cost will be taken out of your Social Security check.

If, in addition to Medicare, you receive an S.S.I.* check or an AFDC** check, Tennessee's Medicaid program will pay the monthly cost of Part B for you.

Medicare and Medicaid Are Not the Same

Most persons age 65 or older and some disabled persons have **Medicare** no matter how much income they have. **Medicaid**, however, pays health care costs only for certain persons who have low income and limited assets. In Tennessee this includes some disabled people, some people in nursing homes and some people with dependent children.

Certain low-income people have both Medicaid and Medicare. Chapter 2 includes a chart which shows how the two programs fit together.

What Medicare Does–and Doesn't Pay

The following chart and description briefly explain the Medicare Program.

To find out more, get a free copy of Your Medicare Handbook at your Social Security office.

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* Supplemental Security Income
** Aid to Families with Dependent Children

SOME OF MEDICARE'S GAPS

SERVICE	Benefit Period	Medicare Pays in 1986	You Are Responsible For
HOSPITALIZATION (Part A): Semi-private room and board Miscellaneous hospital services and supplies, such as: Meals & drugs Special Care Units Diagnostic x-rays Lab tests Operating and recovery rooms	FIRST 60 DAYS	ALL BUT $492	$492
	61st-90th DAYS	ALL BUT $123 A DAY	$123 A DAY
	91st-150th DAYS	ALL BUT $246 A DAY	$246 A DAY
	BEYOND 150 DAYS	NOTHING	100% OF COST
POST-HOSPITAL SKILLED NURSING HOME CARE (SNF CARE) (In a nursing home facility approved by Medicare. You must have been in the hospital for at least 3 days before entering the facility, and care must meet the definition of "skilled nursing care")	FIRST 20 DAYS	100% OF COST	NOTHING
	21st-100th DAYS	ALL BUT $61.50 A DAY	$61.50 A DAY
	BEYOND 100 DAYS	NOTHING	100% OF COST
INTERMEDIATE OR CUSTODIAL CARE in a nursing home		NOTHING	100% OF COST[4]

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[4] Few Medicare Supplement insurance policies cover intermediate or custodial nursing home care. Medicaid covers intermediate care for people who qualify.

SOME OF MEDICARE'S GAPS

	Time Frame	Medicare Pays In 1986	You Are Responsible For
HOME HEALTH CARE (part-time skilled care or therapy which is medically necessary and given by a home health agency approved by Medicare)	UNLIMITED NUMBER OF DAYS	100% OF COST	CUSTODIAL CARE COSTS AND COST OF CARE AFTER MEDICARE SAYS SKILLED CARE IS NO LONGER NECESSARY
HOSPICE CARE (for persons who are not expected to live longer than six months and choose to have this care through a Medicare-approved hospice)	TWO 90-DAY PERIODS PLUS ONE 30-DAY PERIOD PER LIFETIME	DRUGS - 95% OF COSTS PLUS ANY COSTS AFTER YOU PAY $5.00 PER DRUG RESPITE STAY* - 95% OF COSTS PLUS ANY COSTS AFTER YOU PAY $492 PER PERIOD	5% OF DRUGS UP TO $5.00/DRUG 5% OF THE COST OF EACH RESPITE CARE* DAY UP TO $492 PER PERIOD
MEDICAL EXPENSE (Part B): Services of physician Services of speech or physical therapist Use of an ambulance Physician-administered tests Medical supplies other than prescribed drugs and medicines	CALENDAR YEAR	AFTER A $75/YR. DEDUCTIBLE, 80% MEDICARE'S APPROVED CHARGES ON COVERED SERVICES	$75 A YEAR DEDUCTIBLE *PLUS* 20% OF MEDICARE'S APPROVED CHARGES *PLUS* ANY CHARGES HIGHER THAN MEDICARE'S APPROVED CHARGES (UNLESS DOCTOR ACCEPTS ASSIGNMENT) PLUS SERVICES NOT COVERED BY MEDICARE
MEDICINE	BENEFIT PERIOD	100% OF COST IN HOSPITAL OR SNF	100% OF COST OUT OF HOSPITAL OR SNF

*A short-term in-patient stay in a hospital, hospice, or skilled nursing facility.

"Hospital Insurance" - "Part A" Services in Detail

Medicare will not pay for services in all hospitals and nursing homes. You must be in a Medicare - approved facility. Medicare must also be convinced that your stay is medically necessary.

HOSPITAL CARE

For each spell of illness (benefit period) in which you are hospitalized, Medicare's Part A pays part of the cost of hospital inpatient care. During the first 60 days of a Medicare-approved hospital stay, Medicare pays all charges for Medicare-covered hospital services except for $492 (1986 figure), which is the **Part A deductible**. A Medicare "deductible" is the initial part of your bill on which Medicare pays nothing.

From hospital days 61 - 90, Medicare pays all charges for Medicare-covered hospital services except for the **Part A co-insurance** - $123 per day (1986 figure). Medicare "co-insurance" is the part of the bill that you pay when both you and Medicare are paying the bill.

These first 90 days of hospital care can be "renewed." This means you get a new 90 days of Medicare hospital coverage if you start a new benefit period. This occurs after you have been out of the hospital and skilled nursing facility for 60 days in a row.

Lifetime Reserve Days

In addition to these 90 "renewable days," each person with Part A coverage can have 60 more days of Medicare-covered hospital days during their lifetime. These 60 days are your **"lifetime reserve days."** They are used after your ninety days of hospital care in a benefit period. Once a lifetime reserve day is used, it cannot be renewed. Your Part A co-insurance for your lifetime reserve days is $246 a day (1986 figure).

NURSING HOME CARE

Medicare Part A covers the total cost of the first 20 days in a nursing home and part of the cost of the next 80 days, but only if all of these things are true:

- You have been in a hospital for at least 3 days in a row during the 30 days before you went into a nursing home,
- You need skilled nursing care,
- The nursing home is a Medicare-approved skilled nursing facility.

Medicare's coverage of nursing home care is very restricted. Fewer than 1% of Tennesseans over age 65 received Medicare payment for nursing home care in 1982. Only 2.8% of the patient days in Tennessee nursing homes was paid by Medicare in 1984. If you receive "intermediate" care or "custodial" care, (which more people need than skilled care) Medicare will not cover your stay.

HOME HEALTH CARE

Medicare's home health care coverage will not pay for round-the-clock nursing care at home. It will pay the total cost of part-time skilled nursing care and therapy from a Medicare - approved home health agency. You do not have to have been in a hospital first, but the services must be medically necessary and unavailable from anyone else in your home.

HOSPICE CARE

Hospices focus on making a terminally ill patient comfortable rather than on treating his or her illness. Partial coverage for the cost of hospice care is available under Medicare for persons who are not expected to live longer than six more months and who choose to receive this type of care.

What "Part A" Pays For

HOSPITAL AND SKILLED NURSING CARE

- Semi-private room and board
- Nursing services
  (but **not** private duty nurse.)
- Meals
- Drugs
- Medical social services
- Medical supplies & equipment
- Diagnostic tests
- Use of hospital facilities such as operating and recovery rooms
- Physical and speech therapy
- Blood (after the first 3 pints)

HOME HEALTH CARE

- Nursing care and home health aides
- Physical therapy and speech therapy
- Medical supplies and equipment
- Medical social services

HOSPICE CARE

- Nursing care
- Medical social service
- Doctors' services (some duties can only be performed by special doctors)
- Counseling services to terminally ill person and family
- Short-term in-patient care in hospice, hospital or skilled nursing facility
- Medical appliances and supplies, including drugs used primarily to relieve pain
- Home health aide services
- Physical therapy

What "Part A" Does Not Pay For

This is a **partial** list of what "Part A" does **not** cover in 1986:

The "Part A deductible"
(the initial part of the bill on which Medicare pays nothing)

-- $492 for the first 60 days of in-patient hospital care during each benefit period.

Co-insurance
(your part of the bill when both you and Medicare are paying)

For in-patient hospital care in a benefit period you must pay:

-- $123 a day for days 61 - 90
-- $246 a day for days 91 - 150 (lifetime reserve days)

For skilled nursing care in a benefit period you must pay:

-- $61.50 a day for days 21 - 100

For hospice care in each period you must pay:

-- 5% of drugs up to $5.00 per drug
-- 5% of cost of respite care up to $492

Unapproved stays in hospitals or nursing homes:

Unapproved hospitals and skilled nursing facilities

First three pints of blood

Services that are **not medically necessary**

Intermediate or custodial care in a nursing home

Private duty nursing

Private room

Psychiatric hospital care over 190 days in a lifetime. (Psychiatric care in a non-psychiatric hospital is not subject to this lifetime limit).

Medical Insurance: "Part B" Services in Detail

WHAT IS PART B?

"Medical Insurance" or "Part B" is the part of Medicare that helps pay for most doctors' services in or out of the hospital and for a number of other services and items, such as medical equipment, braces, and the use of an ambulance.

Because doctor bills are the type of Part B expenses people most often have, we use the term "doctor bills" in this book to mean any Part B expense. For the most part, what we say about doctor bills is true for all Part B expenses.

Don't just assume that you can tell which part of Medicare a service is under, based on whether the service seems to be a "hospital" or a "medical" service. Some things, such as home health care, can be covered under either Part A or part B, To find out which part applies, ask the provider of the service.

PART B DOES NOT PAY THE WHOLE DOCTOR BILL

When you receive health services which are covered under Part B of Medicare, there are three types of costs you are responsible for paying:

1) The $75 Medicare **deductible**--
Medicare pays nothing toward the first $75 of Medicare-approved doctor bills in each calendar year.

2) The 20% **co-insurance**--
after the $75 deductible, you pay 20% and Medicare pays 80% of the Medicare-approved portion of your doctor bills for the rest of the year.

3) Any **excess charges**--
if your doctor's charges are higher than Medicare's approved charges, you must pay the excess.

APPROVED CHARGES

Medicare's Part B payments are based on "Medicare-approved" charges. Medicare's approved charges are charges that Medicare considers to be "reasonable" for each service performed by each doctor.

Most doctors do charge more than Medicare's approved charge. We call the difference between what the doctor charges (the "billed" charge) and what Medicare approves the "excess charge." These excess charges may equal from 20% to 40% or more of Medicare's approved charge.

Example:

Doctor's bill: $90
Medicare approved: $70 x 20% you pay = $14
Excess charge: $20 x 100% you pay = +$20

Total you pay: $34

"PARTICIPATING" DOCTORS SAVE YOU MONEY

Approximately 24% of Tennessee doctors agreed in 1985 to charge their Medicare patients only as much as Medicare approved. These doctors are called "participating" doctors. Their patients still had to pay the $75 yearly deductible and the 20% co-insurance amount, but they did not have to pay excess charges.

To get the names of doctors who are participating this year in your area of the state, call Medicare toll free at 1-800-342-8900 or, in Nashville, call 244-5600. Tell them what medical specialty and location you are interested in.

MEDICARE ASSIGNMENT

Doctors who are not "participating" may decide on a case-by-case basis whether to charge at the level of Medicare's approved charges or at a higher level. A Medicare assignment is a voluntary agreement between you and the doctor that, for a particular service, the doctor will charge no more than the Medicare-approved charge. This means there is no excess charge. To find out if a doctor or other Medicare Part B provider will accept assignment, ask before you receive the service. If the doctor says "yes," the agreement may only apply to that one service, not to all future care by that doctor.

What "Part B" Pays For

The following services are covered under Medicare Part B. Medicare pays 80% of the approved charges for these services after you have paid the first $75 per year of such charges. You pay the 20% co-insurance plus any excess charges above Medicare's approved charges.

- Doctors' services
- Hospital services as an outpatient
- Rural health clinic services
- Home health service (see footnote on next page)
- Drugs that you cannot give to yourself
- Diagnostic x-ray and laboratory tests
- X-ray therapy, radium therapy, and radioactive isotope therapy
- Surgical dressings, splints, casts
- Durable medical equipment (such as iron lungs, dialysis machines)
- Prosthetic devices
- Braces and artificial limbs
- Ambulance services (when medically necessary)

What "Part B" Does Not Pay For

This is a partial list of what Part B does NOT cover. You are responsible for these expenses:

- The **deductible**:* the first $75 of Medicare's approved Part B charges in each calendar year
- **Co-Insurance***: 20% of Medicare's approved charges
- **Excess charges**: the difference between the billed charge and Medicare's approved charge. Such excess charges occur only if the doctor does not accept assignment.
- Blood: first 3 pints and 20% of Medicare's approved charges thereafter
- Dental care
- Prescription drugs that you give to yourself
- Immunizations (shots to prevent illness), except pneumonia and hepatitis B vaccinations
- Routine physical checkups
- Eye or hearing checks, eyeglasses or hearing aids
- Services that are not medically necessary
- Out-patient psychiatric care beyond the yearly limit.

Each year Medicare covers only up to $312.50 or 62.5% of Medicare's approved charges (whichever is less) for psychiatric services performed by a doctor.

Remember, the $75 Part B deductible, if not already paid, will apply to these psychiatric services, and you will also pay the 20% co-insurance and any excess charges.

Thus, the most that Medicare will pay each year for outpatient psychiatric services, if you have already paid the Part B deductible for other medical services, is $250. If you have not paid the $75 deductible for that year, the most Medicare will pay is $190. This limit on Medicare's payment does not apply to the initial psychiatric evaluation.

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*For some services, you do not have to pay the deductible or co-insurance. These include home health services and ambulatory surgical services. (See Glossary and Appendix III).

Medicare Claims

Medicare will not pay for your care until a "claim" is sent in and processed. Although Medicare is a government program, the paperwork on claims and payment is handled by private companies that are paid by Medicare to do this. Medicare's Part A claims are processed in a different way from Part B claims.

Medicare "Part A" Claims

Medicare-approved hospitals, skilled nursing facilities, and home health agencies submit claims to Medicare for you. In Tennessee, these claims are often then processed by Blue Cross & Blue Shield of Tennessee (which has a contract with Medicare to do this).

When the claim has been processed, you will get a form called "Medicare Benefit Notice." This will show what Medicare has paid and what you must pay.

If Medicare refused to cover all or part of your Part A services, you will get a form called "Notice of Medicare Claim Determination." It will tell what services Medicare did not cover and why.

The hospital, facility, or agency will **bill you directly** for any deductible or co-insurance amounts and for other costs not covered by Medicare.

Medicare "Part B" Claims

Each time Medicare processes Part B claims for you, Medicare will send you a form called "Explanation of Medicare Benefits" (EOMB, for short). **SAVE EACH OF THESE FORMS.**

The "EOMB" form shows you several important things:

- How much of the $75 Part B deductible you have met this year.
- Which claims for payment of doctor bills have been filed
- Whether the doctor accepted assignment
- What Medicare decided on each claim
- What you owe for each service, and
- Whether Medicare is sending its payment to you or to the doctor

The information on the EOMB can help you decide whether to appeal if Medicare did not pay what you think it should have. (Medicare appeals are explained later in this chapter.) You may also have to make a copy of the EOMB to send when you file a claim on your Medicare Supplement Insurance.

Assigned Claims and Medicare's Payment

If the doctor or Part B supplier "participates" or agrees to accept assignment for this particular bill, he or she will submit an "assigned" claim to Medicare for you. Presently, Equitable Life Assurance Society has the contract with Medicare to process the Part B claims in Tennessee. Chart II shows you how to read the form you will get after Equitable has processed an assigned claim. The form is called an "Explanation of Medicare Benefits," or EOMB, for short.

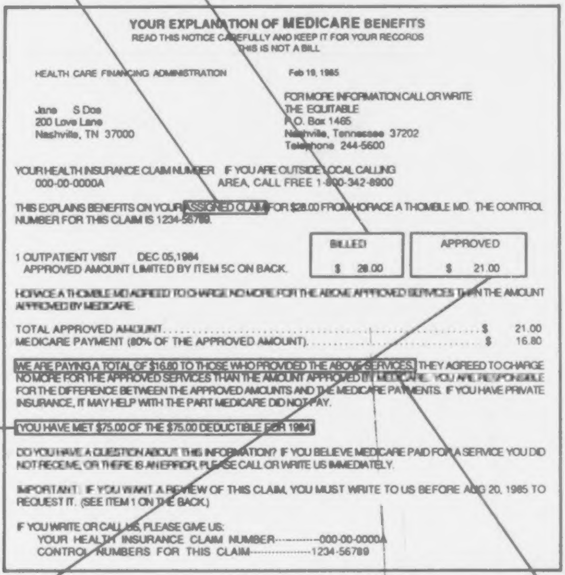
Chart II:

EXAMPLE OF EOMB FOR ASSIGNED CLAIM

① Look here to find out if you have paid your $75 deductible in Medicare approved charges.

② Look at this sentence to find out whether your doctor accepted assignment for this particular bill. If he or she did, it will say "assigned claim."

③ If your doctor accepted assignment, this "billed" amount doesn't matter. It just shows the amount your doctor normally charges for the service you received.



YOUR EXPLANATION OF MEDICARE BENEFITS
READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS
THIS IS NOT A BILL

HEALTH CARE FINANCING ADMINISTRATION

Feb 19, 1985

Jane S Doe
200 Love Lane
Nashville, TN 37000

FOR MORE INFORMATION CALL OR WRITE
THE EQUITABLE
P.O. Box 1465
Nashville, Tennessee 37202
Telephone 244-5600

YOUR HEALTH INSURANCE CLAIM NUMBER
000-00-0000A

IF YOU ARE OUTSIDE LOCAL CALLING AREA, CALL FREE 1-800-342-8900

THIS EXPLAINS BENEFITS ON YOUR ASSIGNED CLAIM FOR $28.00 FROM HORACE A THOMBLE MD. THE CONTROL NUMBER FOR THIS CLAIM IS 1234-56789.

	BILLED	APPROVED
1 OUTPATIENT VISIT DEC 05,1984 APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	$ 28.00	$ 21.00

HORACE A THOMBLE MD AGREED TO CHARGE NO MORE FOR THE ABOVE APPROVED SERVICES THAN THE AMOUNT APPROVED BY MEDICARE.

TOTAL APPROVED AMOUNT .... $ 21.00
MEDICARE PAYMENT (80% OF THE APPROVED AMOUNT) .... $ 16.80

WE ARE PAYING A TOTAL OF $16.80 TO THOSE WHO PROVIDED THE ABOVE SERVICES. THEY AGREED TO CHARGE NO MORE FOR THE APPROVED SERVICES THAN THE AMOUNT APPROVED BY MEDICARE. YOU ARE RESPONSIBLE FOR THE DIFFERENCE BETWEEN THE APPROVED AMOUNTS AND THE MEDICARE PAYMENTS. IF YOU HAVE PRIVATE INSURANCE, IT MAY HELP WITH THE PART MEDICARE DID NOT PAY.

(YOU HAVE MET $75.00 OF THE $75.00 DEDUCTIBLE FOR 1984)

DO YOU HAVE A QUESTION ABOUT THIS INFORMATION? IF YOU BELIEVE MEDICARE PAID FOR A SERVICE YOU DID NOT RECEIVE, OR THERE IS AN ERROR, PLEASE CALL OR WRITE US IMMEDIATELY.

IMPORTANT: IF YOU WANT A REVIEW OF THIS CLAIM, YOU MUST WRITE TO US BEFORE AUG 20, 1985 TO REQUEST IT. (SEE ITEM 1 ON THE BACK.)

IF YOU WRITE OR CALL US, PLEASE GIVE US:
YOUR HEALTH INSURANCE CLAIM NUMBER----------000-00-0000A
CONTROL NUMBERS FOR THIS CLAIM----------1234-56789

④ This is Medicare's approved charge for this particular bill. If your doctor accepted assignment, then this is the amount that he or she agreed to charge. See ⑤ to find out how much of this charge you are responsible for.

⑤ Look at this sentence to find out how much of the approved amount Medicare is paying and to whom they are sending the check. The amount in this sentence should be equal to 80% of Medicare's approved charge. In this example, Medicare pays $16.80 to "those who provided the services," your doctor. **You are responsible for** $4.20, the rest of the approved amount.

When the doctor accepts assignment, the charges to you can be handled in one of two ways.

The doctor may charge you only for the amount Medicare did not pay (i.e., any part of the $75 yearly deductible not yet paid and the 20% co-insurance amount). In this case, Medicare will pay the doctor directly.

On the other hand, the doctor may ask you to pay the whole Medicare-approved amount. Medicare would then send its part of the payment directly to you.

UNASSIGNED CLAIMS AND MEDICARE'S PAYMENT

When the doctor does not "accept assignment" he or she will charge you for the entire cost of care (the billed charge). After a claim is filed, Medicare will pay its share of the cost directly to you.

Even while not accepting assignment, the doctor may still submit the claim to Medicare for you. If not, you will need to submit the claim yourself, using the form called "Request For Medicare Payment" (Form 1490S). You can get this form from your doctor, the Social Security office, or from Equitable at the address that follows. You complete the form, attach an itemized bill, and send it to this address:

Equitable Life Assurance Society
Medicare
P.O. Box 1465
Nashville, TN 37202

After Equitable processes the claim, you will get a copy of the "Explanation of Medicare Benefits" (EOMB) plus payment for Medicare's part of the bill. Chart III shows you how to read the EOMB form on an unassigned claim.

Questions About Claims

Questions about Medicare's Part A coverage should be directed to the insurance company which has the contract to handle Medicare's claims. Ask your hospital or other facility who processes the **Part A** claims. In Tennessee, Blue Cross handles many of these claims and can be contacted at the following address:

Blue Cross & Blue Shield of Tennessee
801 Pine Street
Chattanooga, TN 37402
(615) 755-5600

In Tennessee, questions about Medicare's **Part B** claims may be answered at this address:

Equitable Life Assurance Society
Medicare
P.O. Box 1465
Nashville, TN 37202
(615) 244-5600 or
Toll Free: 1-800-342-8900

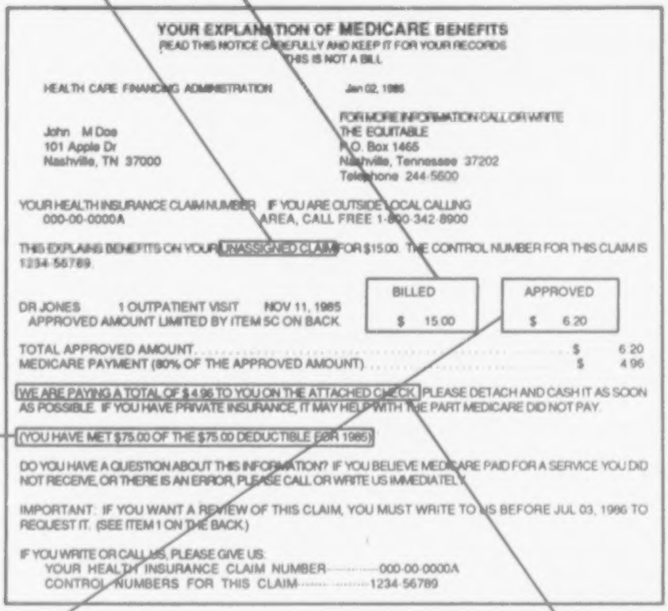
Chart III:

EXAMPLE OF EOMB FOR UNASSIGNED CLAIM

① Look here to find out if you have paid your $75 deductible in Medicare approved charges.

② Look at this sentence to find out whether your doctor accepted assignment. If he or she *did not*, it will say "unassigned claim."

③ If your doctor *did not* accept assignment, then this "billed" amount is what he or she charged. See ⑤ to find out how much of this charge you are responsible for.



YOUR EXPLANATION OF MEDICARE BENEFITS
READ THIS NOTICE CAREFULLY AND KEEP IT FOR YOUR RECORDS
THIS IS NOT A BILL

HEALTH CARE FINANCING ADMINISTRATION
Jan 02, 1986

John M Doe
101 Apple Dr
Nashville, TN 37000

FOR MORE INFORMATION CALL OR WRITE
THE EQUITABLE
P.O. Box 1465
Nashville, Tennessee 37202
Telephone 244-5600

YOUR HEALTH INSURANCE CLAIM NUMBER
000-00-0000A

IF YOU ARE OUTSIDE LOCAL CALLING
AREA, CALL FREE 1-800-342-8900

THIS EXPLAINS BENEFITS ON YOUR UNASSIGNED CLAIM FOR $15.00. THE CONTROL NUMBER FOR THIS CLAIM IS 1234-56789.

	BILLED	APPROVED
DR JONES 1 OUTPATIENT VISIT NOV 11, 1985 APPROVED AMOUNT LIMITED BY ITEM 5C ON BACK.	$ 15.00	$ 6.20

TOTAL APPROVED AMOUNT.......... $ 6.20
MEDICARE PAYMENT (80% OF THE APPROVED AMOUNT).......... $ 4.96

WE ARE PAYING A TOTAL OF $4.96 TO YOU ON THE ATTACHED CHECK. PLEASE DETACH AND CASH IT AS SOON AS POSSIBLE. IF YOU HAVE PRIVATE INSURANCE, IT MAY HELP WITH THE PART MEDICARE DID NOT PAY.

(YOU HAVE MET $75.00 OF THE $75.00 DEDUCTIBLE FOR 1985)

DO YOU HAVE A QUESTION ABOUT THIS INFORMATION? IF YOU BELIEVE MEDICARE PAID FOR A SERVICE YOU DID NOT RECEIVE, OR THERE IS AN ERROR, PLEASE CALL OR WRITE US IMMEDIATELY.

IMPORTANT: IF YOU WANT A REVIEW OF THIS CLAIM, YOU MUST WRITE TO US BEFORE JUL 03, 1986 TO REQUEST IT. (SEE ITEM 1 ON THE BACK.)

IF YOU WRITE OR CALL US, PLEASE GIVE US:
YOUR HEALTH INSURANCE CLAIM NUMBER.......... 000-00-0000A
CONTROL NUMBERS FOR THIS CLAIM.......... 1234-56789

⑤ Look at this sentence to find out how much of the approved charge Medicare is paying and to whom they are sending it. The amount should be equal to 80% of the approved charge if you have paid the $75 deductible. In this example, Medicare pays $4.96 *to you*. **You are responsible for** $10.04, the rest of the billed charge.

④ This is the Medicare approved charge for this particular bill.

When in Doubt, Appeal

If Medicare does not pay for a charge you think should be covered or if Medicare does not pay as much as you think should be paid, you have the right to appeal. An appeal is the process you can use to try to get Medicare to change its decision.

* * * * * * * *

You should not be afraid to appeal if you think Medicare has made a mistake. Sometimes Medicare does not have enough information about your treatment to make a correct decision. Other times an incorrectly filed claim or an error in arithmetic may have caused Medicare to make a mistake.

* * * * * * * *

Filing an appeal will **not** cost you money, and it will **not** affect your Social Security benefits or other Medicare claims. You do not have to have a lawyer or a trained person to assist you with an appeal, but it may be helpful. The nearest legal services or legal care program may be able to help you without charge. (See listing in Chapter 9.)

If you win an appeal, not only will Medicare pay more on your bill, but any Medicare supplement policy you have may also have to increase its payment.

In deciding whether to appeal, you need to look at the reason Medicare turned you down or paid less than you expected. If you cannot tell why Medicare decided as it did, call the doctor, hospital or nursing home involved and also the insurance company which processed the claim for Medicare. Sometimes the only way to get more information is to file an appeal.*

Pay Attention to the Deadlines

Medicare has **strict deadlines for filing appeals.** You can find the last date for filing an appeal by looking on the notice Medicare sent you on that particular claim. If you wait too long, you may be able to appeal or re-open the case if you can show that you had a very good reason for missing the deadline.

A set of booklets called Medicare: Obtaining Your Full Benefits can be very helpful to you in preparing a Medicare appeal. You can order the set of four booklets by sending $19.95, plus $1.00 for postage to the address below:

Legal Counsel for the Elderly
P.O. Box 19269-K
Washington, DC 20036

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* Wayne Moore, Medicare: Obtaining Your Full Benefits, Book 4 (Washington, D.C.: Legal Counsel for the Elderly, 1984), pp. 13-14.

Part A (Hospital or Nursing Home) Appeals

Very few people win at the first step of appealing a decision about payment for care by a hospital, nursing home, hospice, or home health agency.

However, more than 70% of those who go on to the second step do win an increase in payment.*

Look on the **"Notice of Medicare Claim Determination"** to see if it tells you something about why Medicare paid less than you expected. The insurance company that processed the claim for Medicare may be able to tell you more, as may the organization that provided the care.

The first step in an appeal of Medicare's decision about a Part A service is called a "reconsideration." Usually at this step there is no face-to-face hearing. The new decision is usually based on the paperwork in your Medicare file. **You should send in a copy of any written records or statements you can get to prove why Medicare is wrong.** Examples are a letter from your doctor, or a copy of your medical record.

Always keep for yourself the original or a good copy of any important papers you get.

If you lose after the first step of your appeal, you can ask for a hearing, the next step in the appeals process. Again you need to pay **attention to the deadlines.**

A **Medicare hearing is an informal hearing**, not a court of law. You do not have to have a lawyer although it would be helpful.

If you are not satisfied with the decision after the hearing, you can appeal one or two more steps, depending on the amount of money about which you disagree.

Part B (Doctor Bill) Appeals

Only 2% - 3% of Medicare's decisions about doctor bills, therapists, and equipment are appealed, but Medicare increases its payment on more than half of these appeals. **

The **"Explanation of Medicare Benefits"** form should tell you something about why Medicare did not pay as much as you expected. The insurance company that handled the claim for Medicare or the provider who billed you may be able to tell you more.

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* Judith Stein Hulin, Charles C. Hulin and William Dombi, Social Security Practice Guide, Chapter 26, (New York: Matthew Bender Company, 1984), p. 66.

** Moore, p. 13

In general, you should **consider a Part B claim appeal in the following situations:**

--Medicare says your care was not "medically necessary"*

-- Medicare's approved charge is less than 60% of the billed charge.**

-- Medicare didn't pay as much as you expected for physical therapy, oxygen, ambulance service, or for durable medical equipment, such as a wheelchair.***

The first step in a Part B appeal is called a "review." The review is based on the paperwork in your Medicare file.**** To change its decision, Medicare may only need you to send a detailed letter and bill from your doctor describing any complications in your case and the amount of time involved in your treatment.***** It is a good idea to assure the doctor's staff that you are not questioning the doctor's bill. Tell them that you are just trying to make sure that Medicare understands your case and pays the correct amount on the bill.

If you are not satisfied with Medicare's decision after the review, and if the amount of money you disagree about is more than $100, you can ask for a hearing. You do not have to have a lawyer at the hearing, but it is a good idea.

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*Hulin, Hulin and Dombi, p. 74.

**Ibid., p. 51.

***Moore, pp. 13 - 15.

****Ibid., p. 19.

*****Hulin, Hulin and Dombi, p. 50.

YOUR RIGHTS IN A HOSPITAL OR SKILLED NURSING FACILITY

As a person with Medicare, you have certain legal rights when you need care in a hospital or skilled nursing facility. You should be aware of these rights and of how you may be able to use them.

This section explains your rights and actions you can take to protect them in the following situations:

(1) You are worried about going to the hospital because you cannot pay a deposit in advance;

(2) A hospital says your planned stay will not be covered by Medicare;

(3) A hospital wants to discharge you before you feel well enough to leave;

(4) A nursing home says Medicare will no longer pay for your care since you no longer need skilled care.

Problems You Could Face When Being Admitted to a Hospital

What if the Hospital Asks for a Deposit?

(a) If you have Medicare; and

(b) if you need in-patient hospital services covered by Medicare,

then **you cannot be turned away from a hospital just because you cannot afford to pay a deposit in advance.**

In each spell of illness, whenever you are admitted to the hospital for an overnight stay that is covered by Medicare, you will owe the hospital the amount of the Part A deductible-- $492 (1986 figure). But federal law* says that the hospital cannot legally refuse to admit you just because you cannot pay this money in advance.

What if the Hospital Says Your Planned Stay Will Not be Covered by Medicare?

(a) If you have Medicare; but

(b) the hospital says your planned hospital stay will not be covered by Medicare,

then ask the hospital to put their decision **in writing** so you will have the right to appeal if you disagree with this decision.

THE "PRO"

Appeals are decided by a **Peer Review Organization** ("PRO"). The PRO is a group of doctors who have a contract with the government to make sure that hospital care paid for by Medicare is medically necessary and that it is good medical care. If you appeal, the PRO can overrule the hospital's decision and give you Medicare coverage for your planned stay in the hospital.

To win your appeal you may have to show that the care you are to receive is medically necessary and can only be given if you are admitted to the hospital. Your doctor may be able to help you prove this if he or she agrees with you.

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* [42 C.F.R. § 489.22(b)]

CONTACT THE PRO RIGHT AWAY

If you decide to appeal, contact the PRO **within 3 days after you get the hospital's written statement. Ask for a "review"** of the hospital's decision. If you do this, the PRO must send their written decision to you within three working days after they get your request.

If you wait longer than 3 days to ask the PRO for a review, you can still appeal within 60 days, but the PRO can take as long as 30 working days to send you their decision. Presently, this organization serves as the PRO for Tennessee:

Midsouth Foundation for Medical
Care,Inc.
Penn Marc Center
6401 Poplar Avenue, Suite 400
Memphis, TN 38119
(901) 682-0381

The PRO may change from time to time. Check the notice the hospital gives you for the current PRO name and address.

What if You Feel the Hospital is Trying to Discharge You too Early?

After Medicare changed the way it pays hospitals, a government report revealed that a few Medicare patients were being sent home from the hospital before they were well enough. Many people have worried that this could happen to them.

As a Medicare patient, you have a right to stay in the hospital as long as the medical care you need can only be given in a hospital.

Decisions about when you should leave the hospital must be based only on your medical needs, not on Medicare's payment.

Be Prepared

In general we recommend that you take these steps to protect your rights in the hospital:

HAVE AN INFORMED FRIEND OR RELATIVE

Before you go into the hospital, have a friend or family member read this section about your rights. If you are too sick to leave the hospital, you may also be too sick to protect your rights and to make important decisions by yourself.

It is a good idea to have a family member or friend with you when you are being admitted to the hospital and when any important decision is made about your care.

ASK QUESTIONS SO YOU CAN PLAN AHEAD

Before or at the time you go into the hospital, **ask your doctor how long you should expect to stay and whether you will need any special care afterwards. Ask him or her to tell you as soon as possible if these plans change.** This will help you know whether to begin arranging for care at nome or in a nursing facility.

What Can You Do If You Feel You Are Being Discharged Too Soon?

WRITTEN NOTICE

If the hospital tells you that you no longer need hospital care and that Medicare will no longer pay, they cannot start charging you for your care until they have told you this in writing.

NOTE: If you need skilled nursing care but a nursing home bed cannot be found for you, the law says you still need hospital care.

Before the hospital can give you this written notice, they must get either your doctor or the Peer Review Organization (P.R.O.) doctors to agree with them.

IMPORTANT NOTE:

If you leave the hospital without getting a written notice, you give up any right to appeal the hospital's decision.

The hospital cannot charge you for the day you get the written notice or for the day after you get the notice. These are what we call your **two "free days."** After the two "free days," the hospital can start charging you if you stay. For example, if you get a written notice on Monday, the hospital cannot charge you for the care you get on Monday or Tuesday. But they can begin charging you on Wednesday. This is true whether or not you appeal the hospital's decision.

You Can Appeal if You Think the Hospital is Wrong

That is, you can ask the PRO's doctors to consider your case and decide whether Medicare should continue to pay for your hospital bill.

(See the section **"Problems You Could Face When Being Admitted To A Hospital"** earlier in this chapter for more information on the PRO in Tennessee.)

You can ask the PRO to study your case if you leave the hospital or if you stay.

IF YOU STAY AND APPEAL

If you decide to stay in the hospital and appeal, contact the PRO right away so you can get their decision as soon as possible.

The PRO must send you their decision in three working days from the time they hear from you.

But the hospital can start charging you after your two "free days."

Be sure to read **HOW TO APPEAL HOSPITAL OR SKILLED NURSING FACILITY DISCHARGE** at the end of this chapter if you decide to appeal a decision to discharge you before you think you are well enough.

IF YOU WIN

If you stay in the hospital beyond your two "free days" and the **PRO agrees** that your longer stay was medically necessary, **the cost of the additional days will be covered by Medicare.**

IF YOU LOSE

If the PRO decides that **you could have safely left the hospital,** you will have to bear **the full cost of all the days you stayed in the hospital after your two "free days."**

At that point, you can appeal further and hope to win at a higher level of decision-making.

FURTHER APPEALS

There is one more "catch." Even if you win your appeal, the hospital or the doctor can appeal to higher authorities to overrule the PRO's decision. If the hospital eventually wins their appeal, you will still be stuck with the hospital bill for all the days beyond the two "free days." If, in the end, you win, you will be refunded any money you have paid for days that you stayed in the hospital after your two "free days."

AUTOMATIC REVIEW

If you stay in the hospital beyond your two "free days," **the PRO will automatically review your case** even if you do not file an appeal or contact the PRO.

But in that case, the PRO has up to 30 days to decide whether your stay will be covered by Medicare.

IF YOU LEAVE AND THEN APPEAL

Likewise, if you appeal but you leave the hospital during your "free days," the PRO is then allowed to take as long as 30 days to send you a decision.

You may not benefit directly from your appeal even if the PRO decides you were right in saying you needed a longer hospital stay. This is especially true if your health has improved and you no longer need to be in a hospital by the time the PRO makes a decision. Your successful appeal may, however, help other patients because it draws the PRO's attention to a hospital that is acting improperly.

THE HARD CHOICE

You can appeal and stay in the hospital, hoping that you will win your appeal and that you won't have to pay the rest of the hospital bill out of your own pocket.

Or you can leave, hoping you can manage at home or in a nursing home.

You may want to talk about this with a friend or family member. You may also want to call the nearest Legal Services or legal care program (see Chapter 9) to find out if they help` people with Medicare problems and appeals.

What if the Nursing Home Says You no Longer Need Skilled Nursing Care?

As we explained earlier in this chapter, Medicare greatly restricts the nursing home care it pays for. Even if you are one of the few people approved for skilled nursing facility care, you may soon be told that Medicare will no longer help pay for your care because you no longer need skilled care that can only be given if you are an in-patient at a skilled nursing facility.

If you believe the nursing home is wrong, and that you do need that kind of care, **you can appeal the decision to the PRO.** (To find out more about the PRO, see the section **PROBLEMS YOU COULD FACE WHEN BEING ADMITTED TO THE HOSPITAL** earlier in this chapter.)

But a nursing home, unlike a hospital, **does not** have to give you two "free days" of care covered by Medicare after you are told you are ready to leave.

If you stay in the nursing home and appeal, the PRO must tell you within 10 days if they agree that you still need the in-patient skilled care.

If you leave the nursing home and appeal, the PRO can take up to 30 days to give you a decision.

To find out how to appeal a nursing home's decision, see below.

How to Appeal a Hospital or Skilled Nursing Facility Discharge.

It is a good idea to make your appeal to the PRO by telephone immediately. Then follow up with a letter.

The PRO's time limit begins when the PRO receives your telephone request.

When you call:

- Tell the PRO that you want to appeal.
- Tell the PRO why you think you need care that can only be given in a medical facility like the one you are in now.
- Find out the name of the person you talk to, and write it down for your records.

When you write the follow-up letter:

- Give the same information you gave over the phone.
- Tell when you called and who you talked to.
- Send your appeal letter. It is a good idea to send it by certified mail or to get a "proof of mailing" from the post office.

Check your notice from the hospital to see if the address and phone number of the PRO have changed from what is given in our section "Problems You Could Face When Being Admitted to a Hospital."

For More Information:

For more details about your rights in hospital admissions and discharges, write to the American Association of Retired Persons (AARP) at the address below and ask for: **Knowing Your Rights: Medicare's Prospective Payment System.**

Fulfillment
1909 "K" Street, N.W.
Washington, DC 20049

CHAPTER 2: MEDICARE IS NOT ENOUGH -- WHAT CAN YOU DO?

There are a number of ways, some more practical than others, to cope with costs that Medicare does not cover. There is no one ideal solution for everyone, and there is no approach which will make sure that all your health care costs will be covered.

Your choices depend, to some extent, on your financial situation.

If Your Income and Resources Are Limited

If you are on a tight budget, we suggest you do these things,which we say more about below:

-- try to get Medicaid;

-- make the most of your Medicare;

-- decide if you can afford a Medicare Supplement insurance policy.

Try to Get Medicaid

Find out if you are eligible for Medicaid in addition to Medicare. Anyone who gets Supplemental Security Income (S.S.I.) checks automatically qualifies for Medicaid. Also, many people with limited income and resources can get Medicaid if they are receiving skilled or intermediate care in a nursing home. Since the Medicaid rules change from time to time, **anyone with low income or high medical bills should ask at the local office of the Department of Human Services if they can get help from Medicaid.**

To get up-to-date information on Medicaid benefits in Tennessee, you can call toll-free 1-800-523-2863. (In Nashville, call 741-7494 or 741-7495).

IF YOU HAVE BOTH MEDICAID AND MEDICARE

· If you have Medicare and you also have Medicaid because you get an SSI check or an AFDC check, the state will pay the monthly cost of Medicare Part B for you; the cost will NOT be taken out of your Social Security check as is done for most people.

The following chart shows in brief how Medicaid and Medicare fit together for people who have both.

IF YOU HAVE *BOTH* MEDICAID AND MEDICARE

(this is part of what each program pays in Tennessee in April 1986)

	MEDICARE PAYS	MEDICAID PAYS
HOSPITAL STAYS		
First 60 days	All but $492	$492
Day 61-90	All but $123/day	—0—
Day 90-150	All but $246/day	—0—
Beyond 150 days	—0—	—0—
NURSING HOME STAYS		
Skilled Care after hospital stay		
First 20 days	All costs	—
Day 21-100	All but $61.50/day	$61.50/day
After 100 days per benefit period	—0—	All costs for an unlimited number of days*
Intermediate Care	—0—	All costs for an unlimited number of days*
Custodial Care	—0—	—0—
HOME HEALTH CARE	All costs for part-time skilled care or therapy	All costs for up to 60 home health aide visits per year when skilled care is not needed
DOCTOR BILLS	After first $75 each year, 80% of *Medicare's approved* charges	*IF DOCTOR ACCEPTS ASSIGNMENT* FOR BOTH Medicaid and Medicare:** First $75 each year PLUS 20% of Medicare's approved charges IF DOCTOR DOES *NOT* ACCEPT ASSIGNMENT: —0—
MEDICINE	All costs in hospital or skilled nursing care during Medicare approved stays —0— when you are at home	Each month, 7 prescriptions, if they are on the Medicaid list (even if you are at home)

*If approved by Medicaid and meeting all other Medicaid eligibility requirements.

**If doctor accepts assignment of both Medicaid and Medicare, there will be no doctor's charges in excess of Medicare's approved charges.

If you have both Medicaid and Medicare you should keep two points in mind.

(1) To avoid having to pay part of a doctor bill out of your own pocket, make sure that each doctor who treats you accepts assignment for both Medicaid and Medicare. (See "Medicare Assignment" in Chapter 1.)

(2) If you buy a health insurance policy in addition to your Medicaid and Medicare, you will be affected by a new rule: if the policy covers something Medicaid paid for, the policy is supposed to pay Medicaid, not you.

Buying health insurance when you have both Medicaid and Medicare will help you only if these things happen:

(1) you go to doctors who don't accept assignment;

(2) you have to stay in a hospital longer than 60 days (which is rare); or

(3) you lose your Medicaid.

You should ask yourself whether paying for more health insurance with few benefits is worth it when you don't have much money to live on.

Make the Most of Your Medicare Benefits

If your income is limited but you can't get Medicaid, you should be sure to make the most of your Medicare benefits. We recommend you **get Part B Medicare coverage and use doctors who accept Medicare's assignment.**

If you need surgery you may be able to save money by having your operation done without being admitted to the hospital. Medicare will pay the total doctor bill, including the Part B deductible and the co-insurance, if all of the following things are true:

-- the operation is on Medicare's list for 100% payment;

-- the operation is done on an out-patient basis in a hospital or a Medicare-approved ambulatory surgical center (see Appendix III); and

-- the doctor accepts assignment.

If a listed operation is done in a Medicare-approved ambulatory surgical center which accepts assignment, you will save even more money because Medicare pays the total cost of "facility charges" (use of operating and recovery rooms, nursing care, etc). This is true even if your doctor does not accept assignment.

Note: You will still have to pay the Part B deductible and the 20% co-insurance amount for some items, such as a brace, a lens after eye surgery, or medical equipment to use at home.

Decide If You Can Afford a Medicare Supplement Insurance Policy

With Medicare alone you should always be able to get needed in-hospital care, even if you cannot put down a cash deposit when you are admitted.

If you have little income, you should make sure you are able to pay for your basic day-to-day needs, such as food, housing and medicine, before you put money into buying a private health insurance policy.

If you do decide to buy a health insurance policy on a limited budget, we recommend that you buy one of the less costly Medicare Supplement policies .

In 1986 the yearly cost of individual Medicare Supplement policies in Tennessee ranges from less than $250 to more than $1,000 for a 65-year-old person. The cost is usually higher if you have to pay for the policy each month or quarter rather than once a year. Turn to Chapter 6 for a list of the Medicare Supplement policies which are cheapest but which still have several important features.

If Your Income and Resources are Moderate or Better

If your financial situation is moderate or better, you may have more choices in paying for health care, and you may have more assets you want to protect in case of a costly illness. Here are some ways to pay for health care costs not covered by Medicare. Some choices are better than others.

Savings

Savings can be important to cover health costs that are not covered by Medicare or insurance. Such costs include preventive health care, medication, and most nursing home care. But it may be risky to depend on savings alone to cover all costs not covered by Medicare.

Health Maintenance Organizations

Health maintenance organizations (HMOs) are a substitute for health insurance. We do not, however, know of any HMOs in Tennessee which enroll individuals who are not part of an employer group plan. Recent changes in Medicare may encourage HMOs in the future to accept individuals with Medicare.

Group Policy From Employer

If you work in a place that has 20 or more employees and if you go on working after you become eligible for Part A of Medicare, your boss must keep you on the same group health plan that covers everyone else who works there (until you reach age 70). The group health plan will pay first, before Medicare does, for any bills that are covered by the group plan. Your health care coverage will be the same as or better than it was before you had Medicare. If you did not feel the need to buy more insurance in addition to your group plan before you got Medicare, then you don't need to add on another policy now that you have Medicare.

When you retire, you can sometimes continue or convert group health insurance you had while you worked. Be aware that your benefits under these group policies often change once you have Medicare. Coverage that you convert to after retirement varies from policies which are very good to policies which pay nothing after Medicare pays.

Before you retire, be sure to get the facts from your employer about how the group policy will pay in relation to what Medicare does not cover. Ask if you also need a Medicare Supplement policy.

Medicare Supplement Insurance Policies

Unless you belong to a Health Maintenance Organization (HMO) or to an employer group plan that you are sure pays well in relation to the gaps in Medicare's coverage, **we recommend that you buy one Medicare Supplement policy if you can afford it.** These policies do not duplicate what Medicare already covers, and they are highly regulated by law in most states, including Tennessee.

A chart at the end of Chapter 3 shows what a policy must cover if it is a Medicare Supplement". Even the most basic Medicare Supplement policy will give you substantial help for a costly (but unlikely) long hospital stay. It will also give a lot of help with doctor bills if your doctors accept assignment.

A more costly Medicare Supplement policy can also cover the $492 deductible for each hospital stay and can help pay doctor bills that are higher than those Medicare approves (when your doctor does not accept assignment). Chapter 5 includes a list of such policies.

Not All Health Costs Will Be Covered

It is not realistic to expect insurance to cover all your health care costs. Medicare Supplement policies are designed to help fill specific gaps in Medicare's coverage. But they will usually not pay for the kinds of services that are not covered at all by Medicare, such as intermediate care in a nursing home, preventive health care, eyeglasses, dental care, prescriptions, etc.

Buy Only One Medicare Supplement Policy

Some people feel that if having one Medicare Supplement policy is good, then having several would be better. We disagree.

Although you might be able to collect on both policies, we think that any gain in benefits would be more than outweighed by the added cost of a second policy. This is especially true since you are still going to have the out-of-pocket costs for the non-covered services mentioned above, even with a second Medicare Supplement policy.

Other Types of Insurance Have Important Shortcomings Once You Are Enrolled in Medicare.

Major Medical Policy

You can try to buy an individual major medical policy or continue one you already have. However, these are not often sold on an individual basis to anyone already 65 or older, and the cost can be very high. Major medical policies are designed to pay the high cost of long illnesses; they are not specifically designed to fill the gaps in Medicare's coverage.

Indemnity Policy

An indemnity policy will pay you a set amount of money for each day, week, or month you are in a hospital. These policies are not directly related to the gaps in Medicare's coverage. They are often very costly for the limited benefits you get. You may have to wait as long as two years before an indemnity policy will pay for treatment of health problems you had when you took out the policy.

Cancer or "Dreaded Disease" Policies and Other Limited Policies

Many policies pay only for a specific health service, such as intensive care, or for accidents, or for specific diseases, such as cancer. The benefits are not designed to fill Medicare's gaps in coverage. By law, some of these policies have to print the warning, "This is a limited policy, read it carefully," across the front of the policy.

It is better to buy a single Medicare Supplement policy with the benefits you want, rather than a collection of limited policies. This way, your insurance covers all services and diseases except those specifically excluded by the policy itself or by the "pre-existing conditions" section of the policy.

Nursing Home Policies

In 1984 only 1% of nursing home care in the U.S. was paid for by private insurance.

Until recently, most "nursing home," "extended care," or "convalescent care" policies sold in Tennessee had the same shortcomings as Medicare and Medicare Supplement policies. The only type of nursing home care they covered was "skilled nursing care," which is needed much less often than "intermediate care." (See the Glossary for the meaning of "intermediate care.")

During 1985 a number of new nursing home policies were approved for sale by the Tennessee Department of Commerce and Insurance. Some of these do use the terms "intermediate" and "custodial" care as well as skilled care to describe their benefits.

If you are thinking about buying one of these broader nursing home policies, read carefully the "Definitions" section and the conditions under which the policy will pay. Watch for these kinds of limitations:

- Specific health problems which are not covered,
- A waiting period before the policy will cover illnesses you already had when you took out the policy,

- A requirement that you must be in the nursing home a certain number of days before the policy begins to pay,

- A phrase that gives you coverage only if you were in a hospital before being admitted to the nursing home,

- A phrase that gives you coverage of intermediate care only after you have received skilled care for a certain length of time.

Be aware also that if you buy one of these policies, you may be paying for coverage of skilled nursing care which is already covered by Medicare. It may also be covered by your Medicare Supplement policy.

CHAPTER 3: THE MEDICARE SUPPLEMENT INSURANCE LAW

Because so many senior citizens in Tennessee and across the country had had problems when they bought insurance, Tennessee passed a Medicare Supplement Insurance law effective January 1, 1982. It is important that you understand some basics about the law in order to benefit from its full protection.

Recognizing a Medicare Supplement Policy

The Tennessee law applies only to policies specifically designed to meet gaps in Medicare. These policies are labeled Medicare Supplement on the front page and are the only individual (non-group) policies allowed to have that label.

The Medicare Supplement insurance law does not apply to cancer policies, hospital indemnity policies, or any other type of insurance. In fact, when sold to senior citizens, such policies must say in bold print on the front page that they are not Medicare Supplement policies.

Your Rights When You Shop For a Policy

When you, as an older person, shop for insurance, the agent must give you a buyer's guide and an outline of coverage which describes the benefits of the specific Medicare Supplement policy. You will not see the actual policy until you buy it.

After you get the policy, the law gives you at least 10 days to have a "free look" at the actual policy. Some policies give you up to 30 days. To find out which you have, look on the front page. During this time you may return the policy for any reason and get a full refund of your premium. After the "free look" time you may not be able to get a refund.

Prior Illness

An insurance company can refuse to pay for treatment of "pre-existing" medical conditions during the first six months that you have a Medicare Supplement policy. After you have had the policy for six months, the policy must cover "pre-existing conditions" in the same way that it covers new health problems. Other policies which are not Medicare Supplements can refuse to pay benefits for pre-existing conditions for as long as two years.

A "pre-existing condition" for a Medicare Supplement policy is a health problem for which a doctor recommended treatment or gave you advice or treatment during the six months before you took out the policy. A policy's definition of pre-existing conditions cannot consider what happened to your health more than six months before you took out the Medicare Supplement policy.

Chapter 8 gives more information on pre-existing conditions.

Keeping Your Policy in Effect

An insurance company cannot cancel your Medicare Supplement policy just because your health has gotten worse. Check the "Renewal" or "Renewability" section of the policy to see for what reasons the company can cancel the policy. These reasons must be plainly shown on a Medicare Supplement policy (see Chapter 4 under Big Five Feature #1 to find out more.)

Minimum Dollar Benefits

Under the law, a Medicare Supplement policy must pay at least the dollar benefits outlined in the chart at the end of this chapter. The dollar benefits in the chart are related to Medicare's 1986 deductible and co-insurance costs. At least 60 cents of every dollar paid in by policyholders must be paid back in benefits to the company's policyholders as a whole.

The law requires that the benefits paid by a Medicare Supplement policy must automatically increase each time there is an increase in Medicare's deductible and co-insurance costs. The insurance company may be allowed to increase the cost of the policy at the same time.

Rate Increases

The cost of the policy cannot be increased for you alone. Rate increases must have been approved by the state insurance department and must apply to all policyholders in the same "class." (A "class" of policyholders all have one or more things in common, such as their age or sex.)

Complaints

If you have a complaint about an insurance agent or about a policy or a company that is regulated under Tennessee law, call the Tennessee Department of Commerce and Insurance at one of the offices listed at the end of Appendix I. They can contact the agent or the company for you.

Some Medicare Supplement Policies Are Not Under Tennessee's Medicare Supplement Law

Be aware that not all Medicare Supplement policies are regulated by the Tennessee Department of Commerce and Insurance (except in regard to the truth of their advertising.) Some group Medicare Supplement policies and out-of-state group trusts do not have to be approved by our state insurance department. Examples of this kind of group policy are Secure Care, and policies sold by the National Senior Citizens Group Insurance Trust and the American Association of Retired Persons (AARP). A policyholder with a complaint about one of these policies will have to look for help from the group itself or from another state's insurance department.

All of the policies listed in Chapters 5 and 6 of this book are individual (non-group) policies approved by the Tennessee Department of Commerce and Insurance. To find out if a particular policy is approved in Tennessee, call the state insurance department at this number: 1-800-342-4029.

If you want more specific details about this Tennessee law, you can find them at Tennessee Code Annotated, Sections 56-7-1401 et seq., Tennessee Insurance Rule, Chapter 0780-1-45, or call the Tennessee Department of Commerce and Insurance at 1-800-342-4029.

Medicare Benefit or Service	You Pay (If No Insurance)	*Medicare Supplement* Policy Pays At Least (MINIMUM STANDARDS)
IN HOSPITAL: FIRST 60 DAYS	$492 (DEDUCTIBLE)	NOTHING
DAY 61-90	$123 A DAY	$123 A DAY
DAY 91-150	$246 A DAY	$246 A DAY
BEYOND DAY 150 (OR BEYOND DAY 90)*	100% OF COST	90% OF ELIGIBLE EXPENSES FOR 365 DAYS PER LIFETIME
IN SKILLED NURSING FACILITY FIRST 20 DAYS	NOTHING	NOTHING
DAY 21-100	$61.50 A DAY	NOTHING
BEYOND DAY 100	100% OF COST	NOTHING
PART B ELIGIBLE SERVICES:	$75 A YEAR (DEDUCTIBLE)	NOTHING
DOCTOR	20% OF *MEDICARE'S APPROVED* CHARGES	AFTER A MAXIMUM OF $200 A YEAR POLICY DEDUCTIBLE, 20% OF *MEDICARE'S APPROVED* CHARGES, UP TO AT LEAST $5,000 A YEAR
PHYSICAL OR SPEECH THERAPIST		
AMBULANCE	THE DOLLAR AMOUNT IN EXCESS OF *MEDICARE'S APPROVED* CHARGES	
TESTS BY DOCTORS		
MEDICAL SUPPLIES EXCEPT PRESCRIPTION DRUGS		NOTHING

Medicare Supplement policies *do not* have to pay either the Part A or Part B deductible or skilled nursing facility benefits. However, these benefits are provided by *some Medicare Supplement* policies either as a standard part of the policy or through "riders" which you may buy if you wish. Some policies may also offer such benefits as prescription drugs, Part B benefits above Medicare's allowable charges, etc. Chapters 5 and 6 of this report show some policies which have more benefits than the law requires.

***If lifetime reserve days have been used, Medicare hospital benefits end after 90 days.**

CHAPTER 4: CHOOSING A MEDICARE SUPPLEMENT INSURANCE POLICY

Tips on Choosing a Policy

In Tennessee, there are more than 100 individual (non-group) Medicare Supplement insurance policies to choose from in addition to several group policies offered to members of organizations. For a 65-year-old person, the cost varies from under $250 a year to over $1,000 a year. The benefits, beyond what the law requires a policy to have, vary greatly. The rest of this book is designed to help you do "comparison shopping" for a Medicare Supplement policy.

Don't Expect a Policy to Cover Everything

Buying the most coverage you can afford in one Medicare Supplement policy is much better than buying several policies. But don't expect to buy enough insurance to cover ALL health care costs not paid by Medicare.

Talk to Friends

It is a good idea also to talk to friends who have a policy you are considering. They may be able to tell you whether it is hard to file claims with that company and how long it takes the company to pay them.

Stick to the Facts

Do not allow yourself to be misled or intimidated by high pressure sales, scare tactics, famous people on television. Do not depend on an agent's promises about benefits which are not printed on the outline of coverage.

Check the Financial Stability of the Company

Although we list specific Medicare Supplement policies in this book, we have not checked the financial standing of any insurance companies. You should call the state insurance department to get the latest financial information on a company and to find out if their policyholders have had problems collecting on claims. If you live in Tennessee, call the Financial Section of the Tennessee Department of Commerce and Insurance at (615) 741-7068.

Read Chapter 8 If You Already Have Health Problems

Chapter 8 gives tips for finding a suitable policy if you already have health problems. Be sure to read Chapter 8 if one or more of these things is true for you:

(1) If you are under age 65 and have Medicare;

(2) If you have seen a doctor about a health problem or are being treated for one during the six months before you take out a policy;

(3) if you have a history of mental or emotional problems; or

(4) if you have a history of alcohol or drug abuse.

Compare Policies Based on Cost and "The Big Five Features"

We recommend that you base your choice of a policy mostly on the cost in relation to your budget, and on what the policy offers in terms of the five major features which we call "The Big Five." The Big Five features are described later in this chapter.

The cost of a policy is likely to go up almost every year, mostly because of the yearly increase in the Medicare Part A deductible. Some policies also increase the premiums automatically as you grow older. To find out if a particular policy's rates will increase as you grow older, ask the insurance agent. **We recommend that you choose a policy you can continue to afford if the price rises in years to come.** Chapter 5 lists policies which have all of The Big Five features and have a broad range of prices. If you need a cheaper policy, read Chapter 6, which lists the least costly Medicare Supplement policies that have some of "The Big Five" features.

"The Big Five" Features

Four years of talking with senior citizens about their insurance policies have given us a good idea of what most people expect and want from a Medicare Supplement policy. Based on this, we have picked out five policy features (beyond the minimum benefits the law requires a policy to have) that you should consider most when you compare Medicare Supplement policies. We call these policy features "The Big Five." In choosing The Big Five features we took into account three things:

(1) How likely you are to use a particular feature,

(2) The experiences of people we have known whose policies did not have a particular feature,

(3) The policy features that people complained to us about.

We believe that most people who have both Parts A and B of Medicare will be better satisfied with a policy which has all of The Big Five features. Whether or not you decide to get a policy which has all of them, these are the policy features it is important for you to understand.

Each of The Big Five features and our reason for recommending it are described next. To find the names of specific policies which have all these features, see Chapter 5.

Big Five Feature #1: The Policy Is Guaranteed Renewable

A policy with Big Five Feature #1 is "guaranteed renewable". This means the insurance company cannot cancel the policy (refuse to "renew" it) for any reason as long as you make your payments on time. **We recommend that whenever possible, you choose a Medicare Supplement policy that is guaranteed renewable.** All the policies listed in Chapters 5 and 6 are guaranteed renewable.

If a Medicare Supplement policy is not guaranteed renewable, the company must clearly state, in the outline of coverage and in the policy, the conditions under which it can cancel the policy. Often,a policy that is not guaranteed renewable states that the company can cancel your policy if it also cancels the coverage of everyone else in your state who has the policy. This type of policy is risky. In recent years, at least two of this type of Medicare Supplement policy have been cancelled statewide in Tennessee. Thousands of older people lost their health insurance as a result. Some of these people had a hard time getting another policy because of their health. Depending on the policy they chose, some found that, because of their age, they had to pay higher premiums than they had paid on their old policies. They also had to wait several months before the new policies would cover their existing health problems.

Please Note:

The fact that a policy is guaranteed renewable does not mean that it is guaranteed to stay at the same price. The cost of any policy is likely to go up over time as Medicare changes.

Big Five Feature #2:The Policy Pays Medicare's Part A (In-Hospital) Deductible

A policy with Big Five Feature #2 pays the whole Medicare Part A deductible -- $492 in 1986 -- each time you go into the hospital in a new benefit period.(See Glossary for meaning of benefit period.) **We recommend that you choose a Medicare Supplement policy which pays the Part A deductible.** All of the policies listed in Chapters 5 and 6 have this feature.

Although a policy which does not pay this deductible might be cheaper, most people we have talked with want to be sure the deductible is covered whenever they are hospitalized. More than one in every four people in Tennessee who have Medicare and who are over age 65 are admitted to a hospital each year (1982 statistic). Depending on the number and spacing of their hospital stays, some of these patients could be forced to pay the Part A deductible as many as 5 times in one year.

The Medicare Part A deductible will probably continue to rise each year. A policy with Big Five Feature #2 will cover the increased amount as Medicare's deductible rises. The cost of the policy may go up as a result, however.

Big Five Feature #3: On Doctor Bills, the Policy Pays the 20% Co-Insurance After the First $75 of Medicare-Approved Charges

On doctor bills, Medicare pays 80% of Medicare's approved charges after the first $75 of such charges in each calendar year. You are responsible for the $75, the remaining 20% co-insurance, and any "excess Part B charges."

The purpose of Big Five Feature #3 is to show you which Medicare Supplement policies **pay the 20% co-insurance after the first $75 of Medicare-approved charges each year. We recommend that you get a policy which does this.** Not all Medicare Supplement policies do. The law allows policies to make you pay up to $200 of Medicare-approved charges out of your own pocket each calendar year before they have to pay the 20% co-insurance. We call this a "$200 policy deductible." Because of the way Medicare pays--leaving you responsible for 20% of the approved charges after the first $75--your total Medicare-approved doctor bills would have to be over $700 each year before you would have met the $200 deductible and before such a policy would start to pay. Many people have been disappointed, and even bitter, when such a policy did not pay toward their doctor bills, even after many visits. All of the policies in Chapter 5 have Big Five Feature #3.

NOTE:

A few new policies have a different method of paying doctor bills. This method is not Big Five Feature #3 and it is not a $200 policy deductible. These policies give some help with your doctor bills beginning with the first dollar of billed charges each year. After the policies have paid a certain dollar amount, they begin to pay the full billed charge not paid by Medicare (up to a certain limit). Although these policies do not have Big Five Feature #3, they are an improvement over policies with a $200 deductible. The following policies have this new feature: American Integrity Insurance Company, Form MS-85-P; Globe Life and Accident Insurance Company, Form # MCP-4 (with rider MC-130); Liberty National Life Insurance Company, Form #7041; and United American Insurance Company, Form # MAXC+.

Big Five Feature #4: On Doctor Bills, The Policy Pays Part of The Excess Charges

Policies with Big Five Feature #4 help pay the part of a doctor bill that is higher than Medicare's approved charge. We call this part of the bill the doctor's "excess charge". You have excess charges to pay only when your doctor does not accept assignment (see Chapter 1 about "assignment"). Medicare pays nothing toward the doctor's excess charges. We recommend that you choose a policy that pays part of the excess charges IF you go to doctors who don't accept assignment and if you can afford the cost of a policy with this coverage.

The most frequent complaint we hear about Medicare Supplement policies is that they don't pay enough on doctor bills. This is because many doctors in Tennessee do not accept assignment, and many policies do not cover the doctor's excess charges.

Insurance coverage of the excess charges may be unimportant for minor doctor bills, such as an office visit. It can make a big difference, however, in your out-of-pocket costs for a big expense like an operation.

All the policies listed in Chapter 5 and some of the ones listed in Chapter 6 have Big Five Feature #4.

If your doctors accept assignment, look through Chapter 6 for some guaranteed renewable policies which do not pay toward excess doctor bills.

Big Five Feature #5: The Policy Has No Yearly Limit on its Payment For Doctor Bills

Policies with Big Five Feature #5 will continue to pay their share of your doctor bills no matter how much money this involves. We recommend that you choose a policy with this feature. All the policies listed in Chapter 5 and some of the ones in Chapter 6 have Big Five Feature #5.

Tennessee law allows a Medicare Supplement policy to limit to $5,000 the total amount it will pay on your doctor bills each year. Your Medicare-approved Part B expenses would have to be close to $25,000 in a year before such a policy would have paid you the $5,000 limit.

Although most people will not have $25,000 in doctor bills in one year, we believe that they would like to know that their policy would not "run out" on them if they were to have enormous doctor bills one year.

Benefits Not In "The Big Five"

Many Medicare Supplement policies have features not related to "The Big Five." After you have narrowed your choice down to policies which have The Big Five features you want and can afford, these other benefits can be used to help you to decide between two similar policies.

Below are some benefits you might see which are not part of The Big Five.

Prescription Drugs

For some people, prescription drugs are a major, ongoing expense. Medicare does not pay for medicine unless you are in a hospital or are receiving skilled nursing care or hospice care. Only a few Medicare Supplement policies cover drug costs. Policies which do cover prescription drugs often limit their payment to a modest total each year. Also, they may pay only for medicines taken right after a hospital stay. Appendix IV lists the policies which help pay for prescription drugs. It also describes their drug benefits in brief.

Nursing Home Care

Most Medicare Supplement policies provide some coverage of skilled nursing facility care after Medicare has paid for the first twenty days. This benefit is valuable to the few policyholders who have a long Medicare-approved skilled nursing facility stay. But Medicare restricts its approval of skilled nursing care stays so severely that few people will be able to use a policy benefit that is tied to Medicare's approval of the need for skilled care.

A few Medicare Supplement policies pay a limited benefit for intermediate and/or custodial care in a nursing home.

Added Coverage for Very Long Hospital Stays

Medicare stops helping you pay your hospital bill after you have been in the hospital for 150 days in one benefit period (or 90 days if you have already used your 60 lifetime reserve days.) When this happens, if you still need hospital care, all Medicare Supplement policies must pay at least 90 percent of your hospital bill for an additional 365 days per lifetime. Some policies pay more -- up to 100% of the hospital bill for an unlimited number of days. Such long hospital stays, however, are very rare.

This coverage for extended stays applies only when you have used your Medicare lifetime reserve days. It will not help you pay for a longer hospital stay when Medicare says you no longer need hospital care.

Private Duty Nurse

Some policies pay part of the cost of a private duty nurse in the hospital or at home. Read the fine print carefully to find out exactly how much a policy will pay and under what conditions.

Blood

Medicare does not pay for your first 3 pints of blood, in or out of the hospital. Some policies will cover this cost for you.

Comparing Individual Policies to Group Policies Sold Only to Members of Organizations

Many membership organizations, such as professional associations and clubs, offer group health insurance policies, some of which may be Medicare Supplement policies. Examples of such organizations are the Farm Bureau, the American Association of Retired Persons and the Older Women's League.

Study the Outline of Coverage

To evaluate a group policy offered by an organization, check the outline of coverage to make sure it is labeled as a Medicare Supplement policy. Chapter 7 can help you use the outline of coverage to tell which of The Big Five benefits the policy has. Compare costs and benefits of the group policy to those of the policies shown in Chapters 5 and 6. You will see no group policies shown in our book because none that we know of are guaranteed renewable. Most often a group policy says you can keep your coverage as long as

(1) you are a member of the group, and

(2) you pay the premiums on time, and

(3) the group keeps this policy as its group plan.

Talk to Other Members of the Group

It is a good idea to ask other members of the group about their experience collecting on claims through the group policy. Be cautious of groups that you know about only through advertising. It is safest to choose groups whose reputation you know, since the Tennessee Department of Insurance does NOT regulate the benefits, rates, or claims.

CHAPTER 5: POLICIES WITH "THE BIG FIVE" FEATURES

Is This Chapter For You?

This chapter is for people who want and can afford a Medicare Supplement policy with all "The Big Five" features described in **Chapter 4.** If you want a policy that does not have all "The Big Five", or if you cannot afford a policy in this chapter without cutting back on necessities, go on to the policies listed in **Chapter 6.**

The policies shown in this chapter are individual (non-group) Medicare Supplement policies that had been approved for sale in Tennessee by January 31, 1986 and that have all "The Big Five" features described in **Chapter 4.** No group policies are included because we do not know of any that are guaranteed renewable.

Our Policy Descriptions Give You A Starting Point

Our partial descriptions of the policies in this chapter should serve as a starting point for your own more detailed comparisons. From the fact that a policy is included in this chapter you will know these things about it:

(1) That the policy is guaranteed renewable;

(2) That the policy pays Medicare's Part A deductible when you are in the hospital;

(3) That the policy pays the 20% co-insurance after the first $75 of Medicare's approved charges;

(4) That the policy pays part of the doctor's excess charges when the doctor does not accept assignment;

(5) That the policy does not limit the total it will pay on doctor bills each year.

The Policy Descriptions Also Show These Things

From the policy descriptions that follow you can learn these additional things about each policy in this chapter:

(1) The name of the insurance company that sells the policy;

(2) The form number of the policy. (this tells which of the company's Medicare Supplement policies we are describing);

(3) The yearly cost of the policy for a 65-year-old person in Tennessee, including any optional features ("riders") you need to give the policy all of "The Big Five" features;

(4) What the policy pays on doctor bills.

How To Read Our Descriptions Of What The Policies Pay Toward Doctor Bills

We have detailed each policy's payment of doctor bills because these benefits are often hard to understand.

On the left side of each policy description, under **"Policy states--"** you will see the words the policy uses to describe what it pays toward doctor bills.

On the right side of each policy description, under **"This means--"** you will see our explanation of what the policy pays on doctor bills.

Unless otherwise noted, the insurance company confirmed that our explanation means the same thing as the policy language or they could not convince us that our description was incorrect. Where an insurance company did not respond to our letters, a note indicates that, "Our interpretation of the policy was not confirmed by the company."

Under **"This means--"** we show three things about a policy's payment on doctor bills:

(1) Whether the policy pays the $75 Medicare Part B deductible each year;

If it does, we put "YES"under that item.

If it does not, we put "NO".

For example, if a policy does pay the $75 deductible, you will see the following under the **"This means--"** column:

Policy pays $75/yr. Medicare deductible?

Yes

(2) That the policy pays the full 20% co-insurance after the first $75 of Medicare-approved charges each year. This refers to "Big Five" feature #3. If you do not understand this benefit, go back to that section in **Chapter 4.** ALL the policies in this chapter have this benefit, since it is one of "The Big Five" features.

(3) How much of the doctor's excess charges the policy pays. This is "Big Five" feature #4. If you do not understand this benefit, go back to that section in **Chapter 4.**

EXCESS CHARGES

We describe each policy's "excess charges" benefit under the words, **"It also pays on the doctor's excess charges:"**

The "excess charge" is the amount of the doctor bill that is higher than Medicare's approved amount when the doctor does not accept assignment.

The Whole Excess Up To A Stated Limit

When our explanation says a policy pays "the difference between the billed charge and Medicare's approved charge," we mean that it pays the whole excess. If we add the phrase "up to _____% of Medicare's approved charge," the policy will not pay the excess above the stated limit. This is also true if our description includes the sentence, "This benefit will pay no more than ____% of Medicare's approved charge." Whenever possible, we state this limit as a percentage of Medicare's approved amount. You can then compare this limit with the size of the usual excess charge, which is between 20% and 40% of Medicare's approved charge.

A Percentage Of The Excess

When we say a policy says, "____% of the difference between the billed charge and Medicare's approved charge," we mean that it pays a percentage of the excess charge.

The Usual and Customary Charge

When our "excess charges" description says a policy pays "the difference between the usual and customary charge and Medicare's approved amount," we mean that the policy will pay the excess charge up to a limit which is the insurance company's scale of usual charges for that service in your area.

When Doctor Accepts Assignment

In most cases, the policy will not pay toward excess charges if your doctor accepts assignment. This is because there is no "excess charge" on assigned Medicare claims. You owe only the 20% co-insurance after the first $75 when the doctor accepts assignment. But there are a few policies that pay an "excess charge" benefit anyway. For these few policies, our descriptions include the phrase, "It also pays even if there are no excess charges:".

How These Policies Differ

There are many differences among policies in this chapter even though they all have each of "The Big Five" features. The primary differences are these:

(1) Cost, which ranges from $398.00 to $1022.40 per year for a 65-year-old person in Tennessee;

(2) How much of the doctor's excess charges a policy pays; and

(3) The policies' non-Big Five features.

We do not describe the non-Big Five features of policies in this chapter. You can compare them by getting from an agent, an "outline of coverage" for each policy that interests you. **Chapter 7** tells you how to read an "outline of coverage." If you have health problems, be sure to read **Chapter 8** which discusses the non-Big Five features that are especially important for you.

To Compare Excess Charges Payments

If you are particularly interested in the "excess charges" benefit and you want to compare this benefit for several policies described on the following pages, be sure to read the last section of this chapter, "How to Compare Policies Based on What They Pay on Doctors' Excess Charges." It gives some tips on making valid comparisons.

The Listing is Alphabetical

We have listed the policy descriptions in alphabetical order by the name of the insurance company.

Note:

Although we have made every effort to insure the information about the policies in this and other chapters is correct, we urge you to read carefully a policy you buy just to be sure the policy has the features we mention.

Policies That Have What The Law

1	2	3
These policies can't be cancelled as long as you pay the premium- they are guaranteed renewable.	These policies pay Medicare's Part A (In-hospital) deductible of $492.	On doctor bills, these policies pay the 20% co-insurance after the first $75 of Medicare's approved charges.

AMERICAN GENERAL LIFE &
ACCIDENT INS. CO.,
Form #6001 M-2

1986 Cost Per Year at Age 65:
$520.27 (female), $615.11 (male)

Policy's Payment Toward Doctor Bills:

Policy states:

"In each Calendar Year, you must pay the Medicare Part B Eligible Expenses incurred until you have paid the Medicare Part B Deductible. During the Calendar Year in which this policy is issued, the Medicare Part B Deductible must be paid for Eligible Expenses incurred after the Date of Issue. We will then pay 24% of the Medicare Part B Eligible Expenses incurred during the remainder of the Calendar Year. There is no annual or lifetime limit on the amount of Part B benefits we will pay."

This means:

Policy pays $75/year Medicare deductible?

No

Then it pays 20% of Medicare's approved charges (the co-insurance).

It also pays, even if there is no excess charge:

4% of Medicare's approved charges.

PUZZLED? You may need to read Chapter 1 (Medicare), Chapter 3 (the law), or Chapter 4 (The Big Five features) to understand these pages.

Requires and "The Big Five" Features

4

On doctor bills, these policies pay part of the excess charge (the difference between the billed charge and Medicare's approved charge).

5

On doctor bills, these policies have no yearly limit on their payment.

AMERICAN INCOME LIFE INS. CO., Form #H41000 with Rider BQ100

1986 Cost per Year at Age 65: Not confirmed by company. (1985 rate: $736.00)

Policy's Payment Toward Doctor Bills:

Policy states:

"We will pay the Medicare Part B deductible and 40% of the Medicare Part B Eligible Expenses. Total payment from Medicare and this policy will not exceed the actual charge."

This means:*

Policy pays $75/year Medicare deductible?

Yes

Then it pays 20% of Medicare's approved charges (the co-insurance).

It also pays on the doctor's excess charges:

difference between the billed charges and Medicare's approved charges, up to 20% of Medicare's approved charge

*Our interpretation of this policy was not confirmed by the company.

Prices subject to change.
Policies may have other benefits and limitations not shown here.

Policies That Have What The Law

1	2	3
These policies can't be cancelled as long as you pay the premium- they are guaranteed renewable.	These policies pay Medicare's Part A (In-hospital) deductible of $492.	On doctor bills, these policies pay the 20% co-insurance after the first $75 of Medicare's approved charges.

AMERICAN INTEGRITY INS. CO., Form # MMS-84P, Plan V (with coverage of the Part A deductible)

1986 Cost per Year at Age 65: $678.10

Policy's Payment Toward Doctor Bills:

Policy states:

"A. After the applicable calendar year deductible, which is your obligation to pay, a benefit equal to a percentage of the reasonable charges incurred as established by Medicare (Medicare allowable charges) will be paid. This percentage is specified as the MEDICAL CO-INSURANCE PERCENTAGE as shown in the Policy Schedule.

B. For incurred charges which exceed the Medicare allowable charges, a benefit equal to a percentage of such excess charges will be paid, subject to a calendar year deductible amount. The percentage payable is specified as the EXCESS MEDICAL CO-INSURANCE PERCENTAGE as shown in the Policy Schedule. The deductible amount is specified as the EXCESS CHARGES CALENDAR YEAR DEDUCTIBLE AMOUNT as shown in the Policy Schedule.

Excess charges, for purposes of this benefit, will not exceed the lesser of 150% of the Medicare allowable charges or the actual charges incurred. This means that in determining excess charges eligible for coverage, we will establish a maximum charge amount not to exceed 150% of the Medicare allowable charges. If the actual charges made are less than 150% of the Medicare allowable charges, we will use the actual charges incurred as the maximum charge amount. From this maximum charge amount, we will deduct any payment made by Medicare and any payment made by us under benefit A above of this provision. The balance will be the approved excess charges eligible for payment under this benefit. From this excess charges amount we will deduct the Excess Charges Calendar Year Deductible Amount (unless such Deductible has already been satisfied) and pay you a benefit equal to the Percentage specified in the Policy Schedule.

in no event will any benefit be paid in excess of the actual charges incurred."

This means:

Policy pays $75/year Medicare deductible?

No

Then it pays 20% of Medicare's approved charges (the co-insurance).

It also pays on the doctor's excess charges:

> 80% of the difference between the billed charges* and Medicare's approved charges, after you pay the first $200 of such difference each year. Policy's payment for excess doctor bills will not exceed 40% of Medicare's approved charges.
>
> *Up to 150% of Medicare's approved charges.

PUZZLED? You may need to read Chapter 1 (Medicare), Chapter 3 (the law), or Chapter 4 (The Big Five features) to understand these pages.

Requires and "The Big Five" Features

4

On doctor bills, these policies pay part of the excess charge (the difference between the billed charge and Medicare's approved charge).

5

On doctor bills, these policies have no yearly limit on their payment.

AMERICAN NATIONAL INS. CO., Form #GMS-3

1986 Cost per Year at Age 65: $398.00 (female) $482.00 (male)

Policy's Payment Toward Doctor Bills:

Policy states (in part):

"II.4. Charges for medical care must not exceed the regular customary and reasonable charge for such services or supplies. . . .

2. Eligible Expenses incurred in any one Calendar Year will be first applied to satisfy the Part B Deductible Amount;
3. Once Eligible Expenses exceed the Part B Deductible Amount in any one Calendar Year, American National will pay you the Part B Coinsurance Percentage of such excess incurred during that same Calendar Year;
4. The Part B Deductible Amount and the Part B Coinsurance Percentage are as set forth in the Policy Schedule, as it was first issued or in its most recent amendment."

This means:

Policy pays $75/year Medicare deductible?

No

Then it pays 20% of Medicare's approved charges (the co-insurance).

It also pays on the doctor's excess charges:

The difference between the usual and customary charges and Medicare's approved charges.

Prices subject to change.
Policies may have other benefits and limitations not shown here.

Policies That Have What The Law

1	2	3
These policies can't be cancelled as long as you pay the premium- they are guaranteed renewable.	These policies pay Medicare's Part A (In-hospital) deductible of $492.	On doctor bills, these policies pay the 20% co-insurance after the first $75 of Medicare's approved charges.

ATLANTIC AMERICAN LIFE INS. CO.,
Form # MS 2083
(with rider MS2-RA)

1986 Cost per Year at Age 65: $685.00

Policy's Payment Toward Doctor Bills:

Policy states:

"1. After you have paid the Medicare Part B annual deductible in a calendar year, we will pay 100% of the difference between the Medicare eligible charges you incur during the year and the amounts you receive from Medicare for these expenses, subject to but not to exceed 100% of the Medicare allowable charges."

This means:

Policy pays $75/year Medicare deductible?

No*

Then it pays 20% of Medicare's approved charges (the co-insurance).

It also pays on the doctor's excess charges:

The difference between the billed charges and Medicare's approved charges, up to 80% of Medicare's approved charges.

* A rider pays the first $75 per year, for an added cost of $75 per year.

PUZZLED? You may need to read Chapter 1 (Medicare), Chapter 3 (the law), or Chapter 4 (The Big Five features) to understand these pages.

Requires and "The Big Five" Features

4	5
On doctor bills, these policies pay part of the excess charge (the difference between the billed charge and Medicare's approved charge).	On doctor bills, these policies have no yearly limit on their payment.

BANKERS LIFE AND CASUALTY CO.,
Form # GR-75R (with coverage of the Part A deductible and the optional "usual and customary" expense coverage)

1986 Cost per Year at Age 65: $624.65 or $759.05, depending on percentage chosen for the excess charges benefit.

Policy's Payment Toward Doctor Bills:

Policy states:	**This means:**
"[A] family member must first pay the Medicare Part B deductible. Then, we'll pay the Medicare Part B co-payment percentage for any incurred Medicare Eligible Expense. . . . The deductible and co-payment percentages are determined by Medicare. . . .	Policy pays $75/year Medicare deductible? No* Then it pays 20% of Medicare's approved charges (the co-insurance).
When coverage is shown for the family member, we'll pay a percentage of the Usual and Customary charges incurred which exceed the Medicare Eligible Expenses. The percentage is shown in the Schedule."	It also pays on the doctor's excess charges: 50% or 100% of the difference between the usual and customary charges and Medicare's approved charges.

* A rider pays the first $75 per year, for an added cost of $60 per year.

Prices subject to change.
Policies may have other benefits and limitations not shown here.

Policies That Have What The Law

1	2	3
These policies can't be cancelled as long as you pay the premium- they are guaranteed renewable.	These policies pay Medicare's Part A (In-hospital) deductible of $492.	On doctor bills, these policies pay the 20% co-insurance after the first $75 of Medicare's approved charges.

CENTRAL SECURITY LIFE INS. CO.,
Form # 8683 Rev. 4/83
(with rider H98531)

1986 Cost per Year at Age 65: $620.00

Policy's Payment Toward Doctor Bills:

Policy states:	**This means:**
"If a Family Member incurs Part B Medicare eligible expenses, the Company will pay:	Policy pays $75/year Medicare deductible?
a) 100% of the Medicare Part B calendar year deductible, and	Yes
b) 100% of the remaining Medicare eligible expenses, and	Then it pays 20% of Medicare's approved charges (the co-insurance).
c) after the first $200 of charges in excess of the Medicare eligible expenses, 100% of the remaining usual and customary expenses that are in excess of the Medicare eligible expenses (the first $200 of expenses in excess of the Medicare eligible expenses are not paid)."	It also pays on the doctor's excess charges: The difference between the usual and customary charges and Medicare's approved charges, up to 50% of Medicare's approved charges, after you pay the first $200 of such difference each year.

PUZZLED? You may need to read Chapter 1 (Medicare), Chapter 3 (the law), or Chapter 4 (The Big Five features) to understand these pages.

Requires and "The Big Five" Features

4	5
On doctor bills, these policies pay part of the excess charge (the difference between the billed charge and Medicare's approved charge).	On doctor bills, these policies have no yearly limit on their payment.

CENTRAL SECURITY LIFE INS. CO.,
Form # 8683 Rev. 4/83
(with rider H98407)

1986 Cost per Year at Age 65: $600.00

Policy's Payment Toward Doctor Bills:

Policy states:

"If the Family Member incurs Part B Medicare eligible expenses, the Company will pay the percentage stated in the Policy Schedule of such eligible expenses incurred in each calendar year which are in excess of the Part B Medicare deductible. This benefit shall not exceed the difference between the actual charge for such medical service and the amount paid by Part B of Medicare and the Part B Medicare deductible. . . .

[W]e will pay the percentage shown on the Policy Schedule page of the usual and customary expenses as determined by us that are in excess of the Medicare eligible expenses. Benefits must be payable under the MEDICAL INSURANCE BENEFITS (Part B) provision of the policy before any excess charges can be paid under this amendment."

This means:

Policy pays $75/year Medicare deductible?

Yes

Then it pays 20% of Medicare's approved charges (the co-insurance).

It also pays on the doctor's excess charges:

80% of the difference between the usual and customary charges and Medicare's approved charges, up to 40% of Medicare's approved charges.

Prices subject to change.
Policies may have other benefits and limitations not shown here.

Policies That Have What The Law

1	2	3
These policies can't be cancelled as long as you pay the premium- they are guaranteed renewable.	These policies pay Medicare's Part A (In-hospital) deductible of $492.	On doctor bills, these policies pay the 20% co-insurance after the first $75 of Medicare's approved charges.

CONTINENTAL BANKERS LIFE INS. CO. OF THE SOUTH,
Form # GRMS 8/85 (TN)
REV Plan 3

1986 Cost per Year at Age 65: $702.00

Policy's Payment Toward Doctor Bills:

Policy states:	**This means:**
"Unless you elected in the application to eliminate this benefit, we will pay the Part B Deductible imposed by Medicare.	Policy pays $75/year Medicare deductible? No*
B. Other Medicare Approved Services Coverage includes usual and customary charges for:	Then it pays 20% of Medicare's approved charges (the co-insurance).
1. Physician or surgeon services, except routine physical examinations. . . ;	It also pays on the doctor's excess charges:
2. Out-patient services. . .	The difference between the usual and customary charges and Medicare's approved charges.
3. Out-patient physical therapy and speech pathology services.	
4. Ground ambulance to the nearest hospital or skilled nursing facility, or from such facility to the patient's home."	* Plan 1 will pay the first $75 per year, for an added cost of $81 per year.

PUZZLED? You may need to read Chapter 1 (Medicare), Chapter 3 (the law), or Chapter 4 (The Big Five features) to understand these pages.

Requires and "The Big Five" Features

4	5
On doctor bills, these policies pay part of the excess charge (the difference between the billed charge and Medicare's approved charge).	On doctor bills, these policies have no yearly limit on their payment.

CONTINENTAL CASUALTY CO. (CNA),
Form # P1-67720A, Plan 2
(with riders R1-56434-A
and R1-54506-A)

1986 Cost per Year at Age 65: $702.63 (female) and $781.35 (male)

Policy's Payment Toward Doctor Bills:

Policy states:	**This means:**
"We will pay in a calendar year the Eligible Expense You incur not paid by Medicare because of Medicare Part B deductible and co-payment provisions. . . .	Policy pays $75/year Medicare deductible? Yes
We will pay in a calendar year up to an additional 100% of the Part B Eligible Expense you incur not paid by Medicare because of Medicare Part B co-payment provisions."	Then it pays 20% of Medicare's approved charges (the co-insurance). It also pays on the doctor's excess charges: The difference between the billed charges and Medicare's approved charges, up to 20% of Medicare's approved charges.

Prices subject to change.
Policies may have other benefits and limitations not shown here.

Policies That Have What The Law

1	2	3
These policies can't be cancelled as long as you pay the premium- they are guaranteed renewable.	These policies pay Medicare's Part A (In-hospital) deductible of $492.	On doctor bills, these policies pay the 20% co-insurance after the first $75 of Medicare's approved charges.

CONTINENTAL LIFE INS. CO.,
Form # SC-85

1986 Cost per Year at Age 65: $531 to $858 *(depending on percentage and deductible chosen for excess charges benefit)

Policy's Payment Toward Doctor Bills:

Policy states:

"We will pay twenty percent (20%) of the Medicare Allowable Charge, in excess of the Initial Part B Annual Deductible. . . .

After the Calendar Year Deductible for Excess Expense as shown in the Schedule of Benefits on Page 3 has been met, and subject to the Benefit Percentage for Excess Expense shown in the Schedule of Benefits on Page 3, the Company will pay the difference between the Usual and Customary Expenses you incur and the amount approved by Medicare for Part B Medical Expenses.

The maximum benefit you receive under the Medicare Part B Supplementary Benefit and the Excess Part B Expense Benefit, combined, shall not exceed the amount you receive from Medicare for Part B Medical Expenses."

This means:**

Policy pays $75/year Medicare deductible?

No***

Then it pays 20% of Medicare's approved charges (the co-insurance).

It also pays on the doctor's excess charges:

> 10%-100% of the difference between the usual and customary charges and Medicare's approved charges, after you pay the first $0 to $300 of such difference each year. This benefit will pay no more than 60% of Medicare's approved charges.

* If you are in poor health the cost may be 10% to 20% higher.

** Our interpretation of this benefit was not confirmed by the company.

*** A rider can pay the first $75 per year, for an added cost of $62 per year.

PUZZLED? You may need to read Chapter 1 (Medicare), Chapter 3 (the law), or Chapter 4 (The Big Five features) to understand these pages.

Requires and "The Big Five" Features

4

On doctor bills, these policies pay part of the excess charge (the difference between the billed charge and Medicare's approved charge).

5

On doctor bills, these policies have no yearly limit on their payment.

FIRST NATIONAL LIFE INS. CO., Form # MS-183, Option 1

1986 Cost Per Year At Age 65: Not confirmed by company (1985 rate: $773.14)

Policy's Payment Toward Doctor Bills:

Policy states:

"If you, or your covered spouse, incur Medicare Part B Eligible Expenses, we will pay the calendar year deductible applicable to the year expenses were incurred. In addition, we will pay 100% of the actual charges of the provider of services for such Eligible Expenses not paid by Medicare."

This means:*

Policy pays $75/year Medicare deductible?

Yes

Then it pays 20% of Medicare's approved charges (the co-insurance).

It also pay on the doctor's excess charges:

The difference between the billed charges and Medicare's approved charges.

* Our interpretation of this benefit was not confirmed by the company.

Prices subject to change.
Policies may have other benefits and limitations not shown here.

Policies That Have What The Law

1	2	3
These policies can't be cancelled as long as you pay the premium- they are guaranteed renewable.	These policies pay Medicare's Part A (In-hospital) deductible of $492.	On doctor bills, these policies pay the 20% co-insurance after the first $75 of Medicare's approved charges.

FIRST UNITED LIFE INS. CO.,
Form # MS-1

1986 Cost per Year at Age 65: $830.70

Policy's Payment Toward Doctor Bills:

Policy states:	**This means:***
"After you have paid your Medicare Calendar Year Deductible Amount, we will pay a benefit equal to 20% of all actual expenses incurred by you during the calendar year for: 1. Physician services covered under Medicare Part B. 2. All other medical services and supplies covered under Medicare Part B."	Policy pays $75/year Medicare deductible? No Then it pays 20% of Medicare's approved charges (the co-insurance). It also pays on the doctor's excess charges: 20% of the difference between the billed charges and Medicare's charges.

* Our interpretation of this benefit was not confirmed by the company.

PUZZLED? You may need to read Chapter 1 (Medicare), Chapter 3 (the law), or Chapter 4 (The Big Five features) to understand these pages.

Requires and "The Big Five" Features

4

On doctor bills, these policies pay part of the excess charge (the difference between the billed charge and Medicare's approved charge).

5

On doctor bills, these policies have no yearly limit on their payment.

FIRST UNITED LIFE INS. CO., Form # MS-1 (with increased medical benefit rider)

1986 Cost per Year at Age 65: $1022.40

Policy's Payment Toward Doctor Bills:

Policy states:

"After you have paid your Medicare Calendar Year Deductible Amount, we will pay a benefit equal to 20% of all actual expenses incurred by you during the calendar year for:

1. Physician services covered under Medicare Part B.
2. All other medical services and supplies covered under Medicare Part B. . . .

After you have paid your Medicare Calendar Year Deductible Amount, we will pay an additional benefit equal to 15 percent of all actual expenses incurred by you during a calendar year for:

1. Physician services covered under Medicare Part B.
2. All other medical services and supplies covered under Medicare Part B."

This means:*

Policy pays $75/year Medicare deductible?

No

Then it pays 20% of Medicare's approved charges (the co-insurance).

It also pays on the doctor's excess charges:

15% of Medicare's approved charges plus 35% of the difference between the billed charges and Medicare's approved charges.

* Our interpretation of this policy was not confirmed by the company.

Prices subject to change.
Policies may have other benefits and limitations not shown here.

Policies That Have What The Law

1	2	3
These policies can't be cancelled as long as you pay the premium- they are guaranteed renewable.	These policies pay Medicare's Part A (In-hospital) deductible of $492.	On doctor bills, these policies pay the 20% co-insurance after the first $75 of Medicare's approved charges.

GEORGIA LIFE & HEALTH INS. CO., Form # MS100 (86) T

1986 Cost per Year at Age 65: $675.00

Policy's Payment Toward Doctor Bills:

Policy states:

"If the Insured or any Covered Member of the Family incurs Eligible Medical Expenses, as defined, the Company will pay the first $75 of Eligible Medical Expenses in any one calendar year and will pay 100% of the difference between the remaining actual expenses incurred during the year and the amount received from Medicare for these expenses, but the total paid will not exceed 100% of the Medicare eligible charges."

This means:

Policy pays $75/year Medicare deductible?

Yes

Then it pays 20% of Medicare's approved charges (the co-insurance).

It also pays on the doctor's excess charges:

> The difference between the billed charges and Medicare's approved charges, up to 80% of Medicare's approved charges.

PUZZLED? You may need to read Chapter 1 (Medicare), Chapter 3 (the law), or Chapter 4 (The Big Five features) to understand these pages.

Requires and "The Big Five" Features

4

On doctor bills, these policies pay part of the excess charge (the difference between the billed charge and Medicare's approved charge).

5

On doctor bills, these policies have no yearly limit on their payment.

GULF LIFE INS. CO.,
Form # MED-2

1986 Cost per Year at Age 65: $622.68 (female) and $736.04 (male)

Policy's Payment Toward Doctor Bills:

Policy states:

"In each calendar year, you must pay the Medicare Part B Eligible Expenses incurred until you have paid the Medicare Part B Deductible. During the calendar year in which this policy is issued, the Medicare Part B Deductible must be paid for Eligible Expenses incurred after the Date of Issue. We will then pay 24% of the Medicare Part B Eligible Expenses incurred during the remainder of the calendar year. There is no yearly or lifetime limit on the amount of Part B benefits we will pay."

This means:

Policy pays $75/year Medicare deductible?

No

Then it pays 20% of Medicare's approved charges (the co-insurance).

It also pays, even if there is no excess charge:

4% of Medicare's approved charges.

Prices subject to change.
Policies may have other benefits and limitations not shown here.

Policies That Have What The Law

1	2	3
These policies can't be cancelled as long as you pay the premium- they are guaranteed renewable.	These policies pay Medicare's Part A (In-hospital) deductible of $492.	On doctor bills, these policies pay the 20% co-insurance after the first $75 of Medicare's approved charges.

HERMITAGE HEALTH AND LIFE INS. CO., Form # 807-84 (with coverage of the Part A deductible)

1986 Cost per Year at Age 65: $511.48

Policy's Payment Toward Doctor Bills:

Policy states:

"Provided that Medicare has paid its portion of reasonable and customary charges; and provided that, during a calendar year, the Insured has paid the annual deductible amount not paid by Part B Medicare; the Insurer will pay the following:

A. 20 % of the reasonable and customary charges incurred by the Insured for:
1. A hospital's out-patient department,
2. An ambulatory surgical center,
3. Blood, not provided for in Part A,
4. Physician services,
5. Ambulance services; and or
6. Any other Part B Medicare Eligible Expense, Then

B. 80 % of the additional Medicare Eligible Expenses incurred by the insured for non-assigned physician's charges; provided that:
1. During a calendar year, the Insured pays the first $200.00 of the additional expense incurred, and
2. The additional expense incurred does not exceed 150 percent of the reasonable and customary charge."

This means:

Policy pays $75/year Medicare deductible?

No

Then it pays 20% of Medicare's approved charges (the co-insurance).

It also pays on the doctor's excess charges:

> 80% of the difference between the billed charges and Medicare's approved charges after you have paid the first $200 of such difference each year. This benefit will pay no more than 40% of Medicare's approved charges.

PUZZLED? You may need to read Chapter 1 (Medicare), Chapter 3 (the law), or Chapter 4 (The Big Five features) to understand these pages.

Requires and "The Big Five" Features

4	5
On doctor bills, these policies pay part of the excess charge (the difference between the billed charge and Medicare's approved charge).	On doctor bills, these policies have no yearly limit on their payment.

HERMITAGE HEALTH AND LIFE INS. CO., Form # 807-84 (with coverage of the Part A deductible and rider 945-84)

1986 Cost per Year at Age 65: $583.18

Policy's Payment Toward Doctor Bills:

Policy states:

"Provided that Medicare has paid its portion of reasonable and customary charges, and provided that, during a calendar year, the Insured has paid the annual deductible not paid by Part B Medicare, the Insurer will pay the following:

A. 20% of the reasonable and customary charges incurred by the Insured for:
1. A hospital's out-patient department.
2. An ambulatory surgical center.
3. For blood.
4. For physician services.
5. Ambulance services.

Then

B. 90% of the expenses incurred in excess of the reasonable and customary charges incurred by the Insured for non-assigned physician's charges; provided that the Company's liability is limited to the computation of physician's fees measured at 200% of the reasonable and customary charge."

This means:

Policy pays $75/year Medicare deductible?

No*

Then it pays 20% of Medicare's approved charges (the co-insurance).

It also pays on the doctor's excess charges:

90% of the difference between the billed charges and Medicare's approved charges, up to 90% of Medicare's approved charges.

* A rider can pay the first $75 per year, for an added cost of $89.25 per year.

Prices subject to change.
Policies may have other benefits and limitations not shown here.

Policies That Have What The Law

1	2	3
These policies can't be cancelled as long as you pay the premium- they are guaranteed renewable.	These policies pay Medicare's Part A (In-hospital) deductible of $492.	On doctor bills, these policies pay the 20% co-insurance after the first $75 of Medicare's approved charges.

LIBERTY NATIONAL LIFE INS. CO.,
Form # 7038

1986 Cost per Year at Age 65: $630.00

Policy's Payment Toward Doctor Bills:

Policy states:	**This means:**
"[W]e will pay you the Part B coinsurance amount not covered by Medicare. We will not pay benefits under this Section 2 for any portion of the Medicare Part B calendar year deductible. . . .	Policy pays $75/year Medicare deductible? No Then it pays 20% of Medicare's approved charges (the co-insurance).
"[W]e will pay 80% of each subsequent excess expense. We will not pay any portion of the first $150 of excess expenses you incur each calendar year. Any expense over 125% of the Medicare Part B eligible expenses shall not be considered excess expense."	It also pays on the doctor's excess charges: 80% of the difference between the billed charges and Medicare's approved charges, after you pay the first $150 of such difference each year. This benefit will pay no more than 20% of Medicare's approved charges.

PUZZLED? You may need to read Chapter 1 (Medicare), Chapter 3 (the law), or Chapter 4 (The Big Five features) to understand these pages.

Requires and "The Big Five" Features

4	5
On doctor bills, these policies pay part of the excess charge (the difference between the billed charge and Medicare's approved charge).	On doctor bills, these policies have no yearly limit on their payment.

NATIONAL CASUALTY CO.,
Form # 8427RU
(with coverage of the Part A deductible)

1986 Cost per Year at Age 65: $644.00 or $742.00 (female), $750.00 or $857.00 (male), depending on percentage chosen for the excess charges benefit

Policy's Payment Toward Doctor Bills:

Policy states:	**This means:**
"1. You must first pay the Medicare Part B Deductible each Calendar Year;	Policy pays $75/year Medicare deductible? No
2. We will pay benefits for actually incurred Medicare Eligible Expenses at the Medical Expense Percentage elected for the remainder of the Calendar Year."	Then it pays 20% of Medicare's approved charges (the co-insurance). It also pays, even if there is no excess charge: 10% or 20% of Medicare's approved charges.

Prices subject to change.
Policies may have other benefits and limitations not shown here.

Policies That Have What The Law

1	2	3
These policies can't be cancelled as long as you pay the premium- they are guaranteed renewable.	These policies pay Medicare's Part A (In-hospital) deductible of $492.	On doctor bills, these policies pay the 20% co-insurance after the first $75 of Medicare's approved charges.

NATIONAL STATES INS. CO.,
Form # UMS-1 (with rider R-S75)

1986 Cost per Year at Age 65: $646 to $799 (depending on percentage chosen for excess doctor bills)

Policy's Payment Toward Doctor Bills:

Policy states:	**This means:**
"We will pay the calendar year deductible applied by Medicare. Then we will pay 20% of further Medicare-approved expense you may incur. Expenses covered by this Part include but are not limited to; doctors' charges in or out of the hospital; out-patient hospital charges; and ambulance charges. . . .	Policy pays $75/year Medicare deductible? Yes Then it pays 20% of Medicare's approved charges (the co-insurance).
____% of expense of the kind covered by Part B of Medicare, to the extent recognized as the amount for determining payment under Medicare, i.e. Medicare-approved expenses.	It also pays this on the doctor's excess charges: The difference between the billed charges and Medicare's approved charges, up to 10%, 20%, 30%, or 40% of Medicare's approved charges.
The total amount payable under Medicare and this policy, including this rider, shall not exceed the amount of actual expense incurred."	

PUZZLED? You may need to read Chapter 1 (Medicare), Chapter 3 (the law), or Chapter 4 (The Big Five features) to understand these pages.

Requires and "The Big Five" Features

4

On doctor bills, these policies pay part of the excess charge (the difference between the billed charge and Medicare's approved charge).

5

On doctor bills, these policies have no yearly limit on their payment.

NEW YORK LIFE INS. CO.,
Form # 8145-1

1986 Cost per Year at Age 65: $488.40 or $468.60 (female) $528.00 or $508.20 (male) (depending on whether coverage is for individual or for family.

Policy's Payment Toward Doctor Bills:

Policy states:	**This means:**
(1) "We will subtract an amount equal to the Medicare Calendar Year Deductible form whichever of (a) or (b) is greater:	Policy pays $75/year Medicare deductible? No
(a) the charges within reason as defined in this policy; or	Then it pays 20% of Medicare's approved charges (the co-insurance).
(b) the charges that Medicare determines to be reasonable.	It also pays this on the doctor's excess charges:
2) We will pay a benefit equal to 20% of the amount determined in (1) above."	of the difference between the usual and customary* charges and Medicare's approved charges. * As determined by the company

Prices subject to change.
Policies may have other benefits and limitations not shown here.

Policies That Have What The Law

1	2	3
These policies can't be cancelled as long as you pay the premium- they are guaranteed renewable.	These policies pay Medicare's Part A (In-hospital) deductible of $492.	On doctor bills, these policies pay the 20% co-insurance after the first $75 of Medicare's approved charges.

ORANGE STATE LIFE & HEALTH INS. CO.,
Form # OS872

1986 Cost per Year at Age 65: $631.59

Policy's Payment Toward Doctor Bills:

Policy states:	**This means:**
"We will pay the following benefits for the expense incurred by You that is approved under Medicare, Part B:	Policy pays $75/year Medicare deductible? No
The Coinsurance Amounts but not to exceed 25% of the amount paid by Medicare.	Then it pays 20% of Medicare's approved charges (the co-insurance).
We will not pay benefits under this Part 2 for any portion of the Medicare Part B Calendar Year deductible. . . . After you incur $200.00 of out of pocket Excess Expenses in a Calendar Year, We will pay 80% of each subsequent Excess Expense. . . . Any expense incurred over 150% of the Medicare Part B approved amount, shall not be considered Excess Expense and shall not be payable."	It also pays on the doctor's excess charges: 80% of the difference between the billed charges and Medicare's approved charges, after you pay the first $200 of such difference each year. This benefit will pay no more than 40% of Medicare's approved charges.

PUZZLED? You may need to read Chapter 1 (Medicare), Chapter 3 (the law), or Chapter 4 (The Big Five features) to understand these pages.

Requires and "The Big Five" Features

4	5
On doctor bills, these policies pay part of the excess charge (the difference between the billed charge and Medicare's approved charge).	On doctor bills, these policies have no yearly limit on their payment.

ORANGE STATE LIFE & HEALTH INS. CO.,
Form #OS872 (with rider 872-R)

1986 Cost per Year at Age 65: $826.59

Policy's Payment Toward Doctor Bills:

Policy states:

"We will pay the following benefits for the expense incurred by You that is approved under Medicare, Part B:

> The Coinsurance Amounts but not to exceed 25% of the amount paid by Medicare.

We will not pay benefits under this Part 2 for any portion of the Medicare Part B Calendar Year deductible. . . .

After you incur $200.00 of out of pocket Excess Expenses in a Calendar Year, we will pay 80% [with the basic policy and 20% with the rider] of each subsequent Excess Expense . . . .

Any expense incurred over 150% of the Medicare Part B approved amount, shall not be considered Excess expense and shall not be payable."

This means:

Policy pays $75/year Medicare deductible?

No

Then it pays 20% of Medicare's approved charges (the co-insurance).

It also pays on the doctor's excess charges:

> The difference between the billed charges and Medicare's approved charges, after you pay the first $200 of such difference each year. This benefit will pay no more than 50% of Medicare's approved charges.

Prices subject to change.
Policies may have other benefits and limitations not shown here.

Policies That Have What The Law

1	2	3
These policies can't be cancelled as long as you pay the premium- they are guaranteed renewable.	These policies pay Medicare's Part A (In-hospital) deductible of $492.	On doctor bills, these policies pay the 20% co-insurance after the first $75 of Medicare's approved charges.

PHYSICIANS MUTUAL INS. CO., Form # P-393C/622

1986 Cost per Year at Age 65: $670.45 (10% reduction in cost for spouse who also takes the policy)

Policy's Payment Toward Doctor Bills:

Policy states:	**This means:**
"We will pay 100% of the difference between what Medicare Part B pays and your actual charges for Medicare covered services."	Policy pays $75/year Medicare deductible? Yes Then it pays 20% of Medicare's approved charges (the co-insurance). It also pays on the doctor's excess charges: The difference between the billed charges and Medicare's approved charges.

PUZZLED? You may need to read Chapter 1 (Medicare), Chapter 3 (the law), or Chapter 4 (The Big Five features) to understand these pages.

Requires and "The Big Five" Features

4
On doctor bills, these policies pay part of the excess charge (the difference between the billed charge and Medicare's approved charge).

5
On doctor bills, these policies have no yearly limit on their payment.

PHYSICIANS MUTUAL INS. CO., Form # P192 (with rider R179*)

1986 Cost per Year at Age 65: $704.07

Policy's Payment Toward Doctor Bills:

Policy states:

"When Medicare pays part of a medical service, we will pay 100% of the difference between what Medicare Part B pays and your actual charges for Medicare-covered services."

This means:

Policy pays $75/year Medicare deductible?

Yes

Then it pays 20% of Medicare's approved charges (the co-insurance).

It also pays on the doctor's excess charges:

The difference between the billed charges and Medicare's approved charges.

* Rider R179 also includes in-patient private duty nurse benefit, extended skilled nursing facility benefits, and coverage for the first three pints of blood.

Prices subject to change.
Policies may have other benefits and limitations not shown here.

Policies That Have What The Law

1
These policies can't be cancelled as long as you pay the premium- they are guaranteed renewable.

2
These policies pay Medicare's Part A (In-hospital) deductible of $492.

3
On doctor bills, these policies pay the 20% co-insurance after the first $75 of Medicare's approved charges.

PHYSICIANS MUTUAL INS. CO., Form # P192

1986 cost per Year at Age 65: $486.43

Policy's Payment Toward Doctor Bills:

Policy states:

"When medicare pays part of a medical service, we will pay what Medicare doesn't pay, up to 20% of your actual expenses for that service."

This means:

Policy pays $75/year Medicare deductible?

*

Then it pays 20% of Medicare's approved charges (the co-insurance).

It also pays on the doctor's excess charges:

20% of the difference between the billed charges and Medicare's approved charges.

* Pays 20% of the first $75 of expenses each year, including charges that are higher than Medicare's approved charge.

PUZZLED? You may need to read Chapter 1 (Medicare), Chapter 3 (the law), or Chapter 4 (The Big Five features) to understand these pages.

Requires and "The Big Five" Features

4

On doctor bills, these policies pay part of the excess charge (the difference between the billed charge and Medicare's approved charge).

5

On doctor bills, these policies have no yearly limit on their payment.

PHYSICIANS MUTUAL INS. CO., Form # P192 (with rider R161)

1986 Cost per Year at Age 65: $589.63

Policy's Payment Toward Doctor Bills:

Policy states:

"When Medicare pays part of a medical service, we will pay what Medicare doesn't pay, up to 40% of your actual expenses for that service."

This means:

Policy pays $75/year Medicare deductible?

*

Then it pays 20% of Medicare's approved charges (the co-insurance).

It also pays on the doctor's excess charges:

20% of billed charges plus 20% of the difference between the billed charges and Medicare's approved charges.

* Pays 40% of the first $75 of expenses each year, including charges that are higher than Medicare's approved charge.

Prices subject to change.
Policies may have other benefits and limitations not shown here.

Policies That Have What The Law

1	2	3
These policies can't be cancelled as long as you pay the premium- they are guaranteed renewable.	These policies pay Medicare's Part A (In-hospital) deductible of $492.	On doctor bills, these policies pay the 20% co-insurance after the first $75 of Medicare's approved charges.

PIONEER LIFE INS. CO. OF ILLINOIS, Form #8940 (with coverage of Part A deductible)

1986 Cost per Year at Age 65: $633.00

Policy's Payment Toward Doctor Bills:

Policy states:	**This means:**
"A. After you have paid the deductible amount required by Medicare, we will pay 25% of what Medicare pays under Part B; plus B. If you incur any charges in excess of the amounts paid above, and they are considered usual and customary in your area, we will pay for such excess charges after you have paid the first $125 of such excess charges per calendar year. The total amount payable by us shall not exceed 100% of the amount paid by Medicare for that charge. There is no calendar year limit to this benefit. Our payments are subject to the following conditions: 1.If the amount charged by the medical provider is in excess of the usual and customary expense, we will base our payment on the usual and customary expense. 2.Payment must be made under Part B of Medicare for the portion payable Medicare. 3.Our payment does not duplicate a payment made by Medicare."	Policy pays $75/year Medicare deductible? No Then it pays 20% of Medicare's approved charges (the co-insurance). It also pays on the doctor's excess charges: The difference between the usual and customary charges and Medicare's approved charges, after you pay the first $125 of such difference each year. This benefit will pay no more than 60% of Medicare's approved charges.

PUZZLED? You may need to read Chapter 1 (Medicare), Chapter 3 (the law), or Chapter 4 (The Big Five features) to understand these pages.

Requires and "The Big Five" Features

4	5
On doctor bills, these policies pay part of the excess charge (the difference between the billed charge and Medicare's approved charge).	On doctor bills, these policies have no yearly limit on their payment.

PYRAMID LIFE INS. CO.,
Form # H-91-G

1986 Cost per Year at Age 65: $1094.00

Policy's Payment Toward Doctor Bills:

Policy states:	**This means:**
"[W]e will pay:	Policy pays $75/year Medicare deductible?
a.The Calendar Year Deductible;	Yes
b.100% of Medicare's Allowable Charges not paid by Medicare; and	Then it pays 20% of Medicare's approved charges (the co-insurance).
c.100% of the actual charge that is in excess of Medicare's Allowable Charge. However, if the actual charge exceeds the Reasonable and Customary Charge, we will pay 100% of the Reasonable and Customary Charge that is in excess of Medicare's Allowable Charges."	It also pays on the doctor's excess charges: The difference between the usual and customary charges and Medicare's approved charges.

Prices subject to change.
Policies may have other benefits and limitations not shown here.

Policies That Have What The Law

1	2	3
These policies can't be cancelled as long as you pay the premium- they are guaranteed renewable.	These policies pay Medicare's Part A (In-hospital) deductible of $492.	On doctor bills, these policies pay the 20% co-insurance after the first $75 of Medicare's approved charges.

RESERVE LIFE INS. CO.,
Form # PMS86
(with rider RMS 86-2)

1986 Cost per Year at Age 65: $696.00

Policy's Payment Toward Doctor Bills:

Policy states:

"[W]e will pay 20% of Medicare eligible charges incurred by that [Insured] person in a calendar year after the Medicare Part B Deductible.

You must pay the Medicare Part B Calendar Year Deductible. In no case will our payment, when added to Medicare's payment, exceed 100% of usual and customary charges. . . .

The difference between the usual and customary charge and the Medicare eligible charge as shown on the Medicare Explanation of Benefits is an excess charge. When you have incurred $200.00 in excess charges in each calendar year, we will pay 100% of further excess charges incurred in that year."

This means:

Policy pays $75/year Medicare deductible?

No

Then it pays 20% of Medicare's approved charges (the co-insurance).

It also pays on the doctor's excess charges:

The difference between the usual and customary charges and Medicare's approved charges, after you pay the first $200 of such difference each year.

PUZZLED? You may need to read Chapter 1 (Medicare), Chapter 3 (the law), or Chapter 4 (The Big Five features) to understand these pages.

Requires and "The Big Five" Features

4	5
On doctor bills, these policies pay part of the excess charge (the difference between the billed charge and Medicare's approved charge).	On doctor bills, these policies have no yearly limit on their payment.

RESERVE NATIONAL INS. CO.,
Form # MCS-82, Plan 2

Just before this book went to press, we learned that an "excess charges" rider had recently been approved for this policy. With this rider, the policy would have all "The Big Five" features.

Prices subject to change.
Policies may have other benefits and limitations not shown here.

Policies That Have What The Law

1
These policies can't be cancelled as long as you pay the premium- they are guaranteed renewable.

2
These policies pay Medicare's Part A (In-hospital) deductible of $492.

3
On doctor bills, these policies pay the 20% co-insurance after the first $75 of Medicare's approved charges.

STANDARD LIFE & ACCIDENT INS. CO.,
Form # 1223-186 (with coverage of Part A deductible and Part B additional medical benefit)

1986 Cost per Year at Age 65: $613.00, $646.00, or $672.00, depending on percentage chosen for excess charges benefit. (cost reduced 10% for non-smokers)

Policy's Payment Toward Doctor Bills:

Policy states:

"Standard Life will pay a benefit equal to the difference between your Eligible Medical Expenses and the amount paid by Medicare.

PART B ADDITIONAL MEDICAL BENEFIT. If the application shows that this optional benefit was selected, Standard Life will pay a benefit in accordance with the option you selected in the application. The benefit will equal the difference between your actual expenses and your Eligible Medical Expenses up to 20% of Eligible Medical Expenses if the 120% option was selected; up to 30% of Eligible Medical Expenses if the 130% option was selected; or up to 40% of Eligible Medical Expenses if the 140% option was selected."

This means:

Policy pays $75/year Medicare deductible?

No*

Then it pays 20% of Medicare's approved charges (the co-insurance.)

It also pays on the doctor's excess charges:

> The difference between the billed charges and Medicare's approved charges, up to 20%, 30%, or 40%of Medicare's approved charges.

* The first $75 per year can be covered for an added cost of $70 per year.

PUZZLED? You may need to read Chapter 1 (Medicare), Chapter 3 (the law), or Chapter 4 (The Big Five features) to understand these pages.

Requires and "The Big Five" Features

4	5
On doctor bills, these policies pay part of the excess charge (the difference between the billed charge and Medicare's approved charge).	On doctor bills, these policies have no yearly limit on their payment.

STATESMAN NATIONAL LIFE INS. CO., Form # P-220 (with coverage of the Part A deductible)	1986 Cost per Year at Age 65: $691.24

Policy's Payment Toward Doctor Bills:

Policy states:	**This means:**
"[W]e will pay the Calendar Year Deductible (unless optional rider is selected) and that part of those charges not paid by Medicare, however, the total amount paid by Medicare and this policy shall not exceed 150% of the Medicare allowable charge."	Policy pays $75/year Medicare deductible? Yes Then it pays 20% of Medicare's approved charges (the co-insurance). It also pays on the doctor's excess charges: The difference between the billed charges and Medicare's approved charges, up to 50% of Medicare's approved charges.

Prices subject to change.
Policies may have other benefits and limitations not shown here.

Policies That Have What The Law

1	2	3
These policies can't be cancelled as long as you pay the premium- they are guaranteed renewable.	These policies pay Medicare's Part A (In-hospital) deductible of $492.	On doctor bills, these policies pay the 20% co-insurance after the first $75 of Medicare's approved charges.

UNDERWRITERS LIFE INS. CO., Form # H-0004 (with rider R-0050)*

1986 Cost per Year at Age 65: $754.00

Policy's Payment Toward Doctor Bills:

Policy states:

"[W]e will pay 80% of all charges for those services covered by Medicare in excess of the Medicare Eligible Expense after you have paid an out-of-pocket amount for such excess charges. Your out-of-pocket amount for the first policy year is $200.00 (two hundred dollars); the second policy year is $100.00 (one hundred dollars); the third and later policy years, your out-of-pocket expense is $0.00 (zero). All such payments made by Medicare and the Company shall not exceed 100% of the usual and customary charge for such expense."

This means:

Policy pays $75/year Medicare deductible?

No

Then it pays 20% of Medicare's approved charges (the co-insurance).

It also pays on the doctor's excess charges:

> 80% of the difference between the billed charges** and Medicare's approved charges, after you pay the first $200*** of such difference the first year.

* Rider R-0051, which is a prescription drug benefit always accompanies R-0050 and is included in the price shown.

** Up to the usual and customary charge.

*** Reduced to $100 the second year and to $0 in all following years.

PUZZLED? You may need to read Chapter 1 (Medicare), Chapter 3 (the law), or Chapter 4 (The Big Five features) to understand these pages.

Requires and "The Big Five" Features

4

On doctor bills, these policies pay part of the excess charge (the difference between the billed charge and Medicare's approved charge).

5

On doctor bills, these policies have no yearly limit on their payment.

UNITED AMERICAN INS. CO., FORM # MAXC

1986 Cost Per year at Age 65: $693.00

Policy's Payment Toward Doctor Bills:

Policy states:

"We will pay the following benefits for the expense incurred by You that is approved under Medicare, Part B:

> The Co-insurance Amounts but not to exceed 25% of the amount paid by Medicare.

We will not pay benefits under this [Part] for any portion of the Medicare Part B Calendar Year deductible. . . .

After the first $200.00 of Excess Expenses You incur in a Calendar Year, We will pay 80% of each subsequent Excess Expense.

Any expense incurred over 150% of the Medicare Part B approved amount, shall not be considered Excess Expense."

This means:

Policy pays $75/year Medicare deductible?

No

Then it pays 20% of Medicare's approved charges (the co-insurance).

It also pays on the doctor's excess charges:

> 80% of the difference between the billed charges* and Medicare's approved charges after you pay the first $200 of such difference each year. This benefit will pay no more than 40% of Medicare's approved charges.
>
> *Limited to 150% of Medicare's approved charges.

Prices subject to change.
Policies may have other benefits and limitations not shown here.

How to Compare the Policies Based on What They pay on Doctors' Excess Charges

The policies in this chapter use various ways of figuring what part of the doctors' excess charges they will pay.

You can draw only limited conclusions about how the excess charges payment of a policy in one group compares with the payment of a policy in another group.

We have grouped the policies below according to the method we used to figure their excess charges payment. **Among policies in the same group, you can compare the excess charges benefit, using the policy descriptions given earlier in this chapter.** This is true for all the groups except for the group in which the excess charges payments are based on "usual and customary" charges. Each insurance company sets its own scale of usual and customary charges for a medical service and the amounts may differ from company to company.

THESE POLICIES PAY THE DOCTOR'S WHOLE EXCESS CHARGE

A few policies in this chapter pay the doctor's entire excess charge if the service is covered by Medicare. For a person at age 65 in Tennessee, these policies cost from $670.00 to $773.14 per year. The policies are:

First National Life Ins. Co.
Form # MS-183, Option 1

Physicians Mutual Ins. Co.
Form #P 192 (with rider R179)

Physicians Mutual Ins. Co.
Form # P393C / 622

THESE POLICIES PAY THE DOCTOR'S WHOLE EXCESS CHARGE, UP TO A CERTAIN LIMIT

The policies in this group pay the doctor's whole excess charge as long as it does not exceed a stated limit. If a charge is higher than the limit, then the company will pay only for the part of the bill that is within the limit. The limit on the "excess charges" payment ranges from 10% to 80% of Medicare's approved charges, depending on the policy.

The policies in this group cost from $520 a year for a 65-year-old woman to $826.59 per year for a man or woman of that age in Tennessee. The policies are:

American Income Life Ins. Co.
Form # H41000, with BQ100

Atlantic American Life Ins. Co.
Form # MS 2083, with rider MS2-RA

Continental Casualty Co. (CNA)
Form # P1-67720-A, Plan 2
with riders R1-56434A and R1-54506A

Georgia Life and Health Ins. Co.
Form # MS100 (86) T

National States Ins. Co.
Form # UMS-1 with rider R-S75

Orange State Life and Health Ins. Co.
Form # OS872 with rider 872-R

Standard Life and Accident Ins. Co.
Form # 1223-186
with coverage of Part A deductible and Part B additional medical benefit

Statesman National Life Ins. Co.
Form #P-220
with coverage of Part A deductible

THESE POLICIES PAY A PERCENTAGE OF THE DOCTOR'S EXCESS CHARGE

The policies in this group pay an "excess charges" benefit that is a percentage (from 20% to 90%) of the doctor's excess charge. Some of these policies require you to be responsible for the first $150 or $200 of doctor's excess charges each year before they begin to pay this benefit. Some also have a limit on the amount the policy will pay toward each excess charge ranging from 20% to 90% of Medicare's approved charge.

The annual cost of these policies for a 65-year-old person in Tennessee ranges from $483.43 to $1022.40.

Obviously, these policies would never pay as much of the doctor's excess charge as would a policy in the first group. But some of them might, on occasion, pay more of the excess charge than some of the policies in the second group that have a low limit on payment.

The policies in this group are:

American Integrity Ins. Co.
Form # MMS-84-P, Plan V
with coverage of the Part A deductible

First United Life Ins. Co.
Form # MS-1 and
MS-1 with increased medical benefit rider

Hermitage Health and Life Ins. Co.
Form # 807-84
with coverage of the Part A deductible
and Form # 807-84
with coverage of the Part A deductible
and rider 945-84

Liberty National Life Ins. Co.
Form # 7038

Orange State Life and Health Ins. Co.
Form # OS872

Physicians Mutual Ins. Co.
Form # P192
Form # P192 with rider R 161

Underwriters Life Ins. Co.
Form # H-0004 with rider R-0050

United American Ins. Co.
Form # MAXC

THESE POLICIES PAY AN ADDED PERCENTAGE OF MEDICARE'S APPROVED CHARGES

Three policies in this chapter pay an added percentage of Medicare's approved charge, regardless of the size of the excess charge and regardless of whether the doctor accepts assignment. The percentage ranges from 4% to 20%, depending on the policy.

These policies cost from $520 per year for a 65-year-old woman in Tennessee to $857 per year for a man. The policies are:

American General Life & Accident Ins.
Co Form # 6001 M-2

Gulf Life Ins. Co.
Form # MED-2 (I-85)

National Casualty Co.
Form # 8427 RU
with coverage of the Part A deductible

THESE POLICIES PAY BASED ON THE "USUAL AND CUSTOMARY" CHARGES FOR DOCTOR'S SERVICES

The remaining policies in this chapter pay an "excess charges" benefit based on the company's scale of the "usual and customary" charges for the service in your area. You cannot predict how close a policy's usual and customary charge will be to your doctor's billed charge. Nor can you tell how the payment of one of these policies will compare, in every case, to that of another policy in this group or of a policy in another group.

Some of the policies pay the whole usual and customary charge, and some pay a set percentage of it, ranging from 10% to 80%. Some have an "excess charge" deductible you must pay first. Some also set a limit on their "excess charges" benefit that ranges from 40% to 60% of Medicare's approved charge. The yearly cost of these policies for a 65-year-old in Tennessee varies from $398 (for a woman) to $1094.

The policies in this group are:

American National Ins. Co.
Form # GMS-3.

Bankers Life and Casualty Co.
Form # GR-75R with coverage of
the Part A deductible

Central Security Life Ins. Co.
Form # 8633 Rev. 4/83 with rider
H98407 and Form # 8683 Rev. 4/83
with rider H98531

Continental Bankers Life Ins. Co.
Form # GRMS 8/85 (TN) Plan 3

Continental Life Ins. Co.
Form # SC-85

New York Life Ins. Co.
Form # 8145-1

Pioneer Life Ins. Co. of Illinois
Form # 8940
with coverage of Part A deductible

Pyramid Life Ins. Co.
Form # H-91-G

Reserve Life Ins. Co.
Form # PMS86 with rider RMS86-2

CHAPTER 6: LEAST COSTLY INDIVIDUAL POLICIES

This chapter is for you if you cannot afford or do not want a policy that is shown in Chapter 5. We list in this chapter Medicare Supplement policies that have all of these features:

(1) In 1986, each policy **costs less than $500 a year for a 65-year-old** person in Tennessee.

(2) Each policy **is guaranteed renewable.** (This is Big Five Feature #1 -- See Chapter 4 for more details on it.)

Group policies are not included in this chapter because we do not know of any that are guaranteed renewable.

(3) Each policy **pays the Medicare Part A (In-hospital) deductible.** (This is Big Five Feature #2 -- See Chapter 4.)

Although these policies are alike in the three features shown above, they vary greatly in their coverage of doctor bills. Our chart shows you whether each policy has Big Five Features #3, 4, or 5, which deal with payment of doctor bills. (See Chapter 4 for a detailed description of these three benefits).

If a policy has either "Yes" or "No Yearly Limit" in all three columns, it has all of "The Big Five" features. You can find out more about how it pays on doctor bills by looking up the policy in Chapter 5.

We have listed the policies in order by price, **from the least to the most costly.** We also give you the **policy form number,** which identifies a particular policy, as opposed to all the other kinds of policies an insurance company may sell.

Least Costly Guaranteed Renewable Policies That Pay the Part A (In-Hospital) Deductible

	The Three "Big Five" Features That Deal With Doctor Bills		
Policies Listed from Lowest to Highest 1986 Cost Per Year At Age 65	3 On doctor bills, policy pays the 20% co-insurance after the first $75 of Medicare's approved charges	4 On doctor bills, policy pays part of the excess charges (higher than Medicare's approved charges)	5 On doctor bills, policy limit on how much it will pay each year:
Guarantee Reserve Life Ins. Co. Form # 8015 $264.00 (1985 rate)	No	No	$5,000 Limit
Statesman National Life Ins. Co. Form # P-193 $269.50	No	No	$50,000 Limit
Continental Bankers Life Ins. Co. of the South Form # SMS 10/85 $288.00 (outside of Davidson, Shelby and Hamilton counties)	Yes, if you pay $84.00 extra	No	No Yearly Limit
Guarantee Reserve Life Ins. Co. Form # 8016 $298.00 (1985 rate)	No	No	$10,000 Limit
Continental Bankers Life Ins. Co. of the South Form # SMS 10/85 $324.00 (Davidson, Shelby and Hamilton counties)	Yes, if you pay $96.00 extra	No	No Yearly Limit

The Three "Big Five" Features That Deal With Doctor Bills

Policies Listed from Lowest to Highest 1986 Cost Per Year At Age 65	3 On doctor bills, policy pays the 20% co-insurance after the first $75 of Medicare's approved charges	4 On doctor bills, policy pays part of the excess charges (higher than Medicare's approved charges)	5 On doctor bills, policy limit on how much it will pay each year:
Continental Casualty Co. (CNA) Form # P1-67720-A Plan 1 For Female $326.01	No	Yes, if you pay $205.90 extra	No Yearly Limit
Southwestern General Life Ins. Co. Form # 8140A For Female $336.40	No	No	No Yearly Limit
American General Life & Accident Ins. Co. Form #6001 M-1 For Female $348.36	No	No	No Yearly Limit
Continental Casualty Co. (CNA) Form # P1-67720-A Plan 1 For Male $376.55	No	Yes, if you pay $229.40 extra	No Yearly Limit
Gulf Life Ins. Co. Form # MED-1 (1-85) For Female $378.40	No	No	No Yearly Limit
Associated Doctors Health & Life Ins. Co. Form # MCS-359 $381.39	No	No	No Yearly Limit

The Three "Big Five" Features That Deal With Doctor Bills

Policies Listed from Lowest to Highest 1986 Cost Per Year At Age 65	3 On doctor bills, policy pays the 20% co-insurance after the first $75 of Medicare's approved charges	4 On doctor bills, policy pays part of the excess charges (higher than Medicare's approved charges)	5 On doctor bills, policy limit on how much it will pay each year:
World Ins. Co. Form # A2485 $382.00 (1985 rates)	Yes	Yes, if you pay $53.20 extra	$10,000 Limit
Southwestern General Life Ins. Co. Form # 8140A For Male $384.30	No	No	No Yearly Limit
American National Ins. Co. Form # GMS-3 For Female $398.00 (1985 rates)	Yes	Yes	No Yearly Limit
American General Life & Accident Ins. Co. Form # 6001 M-1 For Male $405.57	No	No	No Yearly Limit
National Health Ins. Co. Form # MSII $425.10	No	No	$ 5,000 Limit
Reserve National Ins. Co. Form # MCS-82 (Plan 2) $435.00*	No	**	No Yearly Limit

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* Price increases because you grow older

**Just before going to press, we learned that an "excess charges" rider was approved for this policy.

The Three "Big Five" Features That Deal With Doctor Bills

Policies Listed from Lowest to Highest 1986 Cost Per Year At Age 65	3 On doctor bills, policy pays the 20% co-insurance after the first $75 of Medicare's approved charges	4 On doctor bills, policy pays part of the excess charges (higher than Medicare's approved charges)	5 On doctor bills, policy limit on how much it will pay each year:
Gulf Life Ins. Co. Form # MED-1 (1-85) For Male $441.92	No	No	No Yearly Limit
Bankers Life & Casualty Co. Form #GR-75R $457.19 (1985 rates)	Yes	Yes, if you pay $130.47 or $260.83 extra	No Yearly Limit
Nationwide Mutual Ins. Co. Form # 1522 For Female $460.00 (1985 rates)	Yes	No	No Yearly Limit
American Income Life Ins. Co. Form # H42000 $465.00	Yes	No	No Yearly Limit
New York Life Ins. Co. Form # 8145-1 For Female $468.60 (Family policy)	Yes	Yes	No yearly Limit
Central Security Life Ins. Co. Form # 8683 with rider H98407 $470.00	Yes	Yes, if you pay $130.00 extra	No Yearly Limit

The Three "Big Five" Features That Deal With Doctor Bills

	3	4	5
Policies Listed from Lowest to Highest 1986 Cost Per Year At Age 65	On doctor bills, policy pays the 20% co-insurance after the first $75 of Medicare's approved charges	On doctor bills, policy pays part of the excess charges (higher than Medicare's approved charges)	On doctor bills, policy limit on how much it will pay each year:
American National Ins. Co. Form # GMS-3 For Male $482.00	Yes	Yes	No Yearly Limit
Southland Life Ins. Co. Form # 12590-84 $482.40 (1985 rates)	No	No	$25,000 Limit
Physicians Mutual Ins. Co. Form # P192 $486.43	Yes	Yes	No Yearly Limit
New York Life Ins. Co. Form #8145-1 For Female $488.40 (Individual Policy)	Yes	Yes	No Yearly Limit
Liberty National Life Ins. Co. Form # 7055 $490.00	No	No	No Yearly Limit
Pyramid Life Ins. Co. Form # H-92-G $490.00 (1985 rates)	Yes	No	No Yearly Limit
American Republic Ins. Co. Form # A-2400 TN-1-82 $491.96	Yes	Yes, if you pay $108.00 extra	$100,000 Limit

The Three "Big Five" Features That Deal With Doctor Bills

Policies Listed from Lowest to Highest 1986 Cost Per Year At Age 65	3 On doctor bills, policy pays the 20% co-insurance after the first $75 of Medicare's approved charges	4 On doctor bills, policy pays part of the excess charges (higher than Medicare's approved charges)	5 On doctor bills, policy limit on how much it will pay each year:
United American Ins. Co. Form # DMXC $495.00	No	No	No Yearly Limit
Continental Casualty Co. (CNA) Form #P1-67720-A Plan 2 For Female $496.73	Yes	Yes, if you pay $205.90 extra	No Yearly Limit
Preferred Risk Life Ins. Co. Form # L5223 $498.00 (1985 rates)	Yes	No	No Yearly Limit
Continental Life Ins. Co. Form # SC85 $498.00	Yes, if you pay $20.00 extra	Yes, if you pay between $13.00-$340.00 extra	No Yearly Limit

CHAPTER 7: UNDERSTANDING A POLICY

USING AN OUTLINE OF COVERAGE TO UNDERSTAND AND COMPARE POLICIES

Why Read the Outline of Coverage?

Once you have decided on one policy or on a few policies you are interested in, you should get an outline of coverage for each one from an agent or from the insurance company. (See Appendix II for addresses of companies.) The outline of coverage is the only reliable source of information that you can get from the company before you buy the policy. The company won't send you the policy itself until after you buy it. The outline of coverage will tell you the price of the policy and will give you information about features that we have not included in Chapters 5 or 6.

BE SURE IT'S AN OUTLINE
Be sure to get an outline of coverage, not an advertising brochure. You can tell the difference between the two because an outline will say "outline of coverage" at the top, under the company name. An outline of coverage is more useful than a brochure because under Tennessee law, the outline must include all the information about a policy that you most need to know. The law also requires that each outline of coverage present the information you need in roughly the same order. This makes it easier for you to compare one policy's outline to another.

HERE'S WHAT THE OUTLINE TELLS YOU
Once you have the outlines of coverage, you should read each one to find three kinds of information:

(1) The price of the policy for your age group,

(2) any "Big Five" features it has, and

(3) any extra (non-Big Five) features it has.

You can find this information on the outline of coverage by using the instructions on the next few pages.

Getting Ready To Take Notes

We recommend that you follow these steps before you begin to read your outlines of coverage:

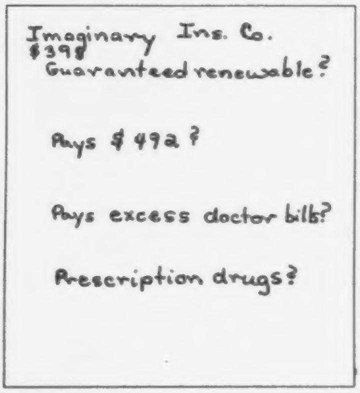
(1) Gather all the outlines of coverage for the policies you are interested in.
(This may be only one policy.)

(2) Use one piece of paper for each policy. At the top of each sheet of paper, write the name of the insurance company and the policy form number. The "form number" distinguishes this particular policy from all the other kinds of insurance the company sells.

(3) Then write the cost of the policy for your age group. You can find this on the outline of coverage after the "renewability" section. It is usually at the end of the outline of coverage.

(4) Decide which of the Big Five features and extra (non-Big Five) features that you want in a policy. Make up a short phrase for each of these features. For example, "Pays $492?" could mean Big Five feature #2.

(5) On the page you have made for each policy, write the phrases you made up for the features. Leave some space under each feature to write notes. See our example below:



Imaginary Ins. Co.
$398
Guaranteed renewable?

Pays $492?

Pays excess doctor bills?

Prescription drugs?

Set up a page for each policy in the same way.

How To Take Notes

Using the instructions on the next few pages, go through the outlines of coverage one at a time. Write under each feature, whether or not the policy has that feature. Do not leave the space under the feature blank. If you could not find the feature, put a question mark. If the policy has a feature, write down any limitations or details about that feature, such as how much it pays and what it covers. You should also write down whether a certain feature costs extra. If it does, put "$_______extra". Fill in the blank with the cost of the feature.

How to Find the Big Five Features in an Outline of Coverage

We suggest the first step you take is to find out what Big Five features the policy has. (See Chapter 4.) That is, find out if the policy is guaranteed renewable (Big Five feature #1), whether it pays Medicare's Part A (in-hospital) deductible (Big Five feature #2), whether it pays the 20% co-insurance for doctor bills after your first $75 of Medicare-approved charges each year (Big Five feature #3), whether it helps pay excess charges on doctor bills (Big Five feature #4), and whether there is a limit on what the policy will pay on doctor bills in a year (Big Five feature #5).

How to Find Big Five Feature #1

To find out if the policy is guaranteed renewable, look for the section on the outline labeled "renewability" or for a section with another heading that means the same thing. The policy is guaranteed renewable if it says that it will not be cancelled as long as you pay your premiums on time. If it gives any other reason that it can be cancelled, the policy is not guaranteed renewable . (See Chapter 4 to find out more about guaranteed renewable policies.)

Find the Chart

To find Big Five features numbers 2-5, you should first locate the chart in your outline of coverage. This chart will have most of but not all the information you need for each feature.

HOW TO FIND BIG FIVE FEATURE #2

To find out if a policy pays for Medicare's Part A deductible of $492, look in the area of the chart that we have shaded in gray. See below.

Within the area that we have shaded in gray, look at the block below the words "This Policy Pays". Be careful because more than one policy may be described on your chart. In that case, just look for the area labeled as being for your policy.

Service	Benefit Period	Medicare Pays	This Policy Pays	You Pay
HOSPITALIZATION... Semiprivate room and board, general nursing and miscellaneous hospital services and supplies Includes meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room anesthesia and rehabilitation services	First 60 days	All but $492	$492	—0—
	61st to 90th day	All but $123 a day		
	91st to 150th day	All but $246 a day		
	Beyond 150 days	Nothing		
POSTHOSPITAL SKILLED NURSING CARE... In a facility approved by Medicare, you must have been in a hospital for at least three days and enter the facility within 30 days after hospital discharge	First 20 days	100% of costs		
	Additional 80 days	All but $61.50 a day		
	Beyond 100 days	Nothing		
MEDICAL EXPENSE	Physician services inpatient and outpatient medical services and supplies at a hospital, physical and speech therapy and ambulance	80% of reasonable charge (after $75 deductible)		

HOW TO FIND BIG FIVE FEATURES #s 3-5

To find out how much a policy pays on doctor bills, you should look in the area of the chart that we have shaded gray below:

Within that area, find the box in the "This Policy Pays" column. If there is an * next to one of the words in the box, look for a note below the chart which will tell what the company means when it uses this word. Also look over the rest of the outline for a "definitions" section which might tell the meaning of some of the words in the box. (See Chapter 4 to find out more about Big Five features #s 3-5.)

Service	Benefit Period	Medicare Pays	This Policy Pays	You Pay
HOSPITALIZATION... Semiprivate room and board, general nursing and miscellaneous hospital services and supplies Includes meals, special care units, drugs, lab tests, diagnostic x-rays, medical supplies, operating and recovery room anesthesia and rehabilitation services	First 60 days	All but $492		
	61st to 90th day	All but $123 a day		
	91st to 150th day	All but $246 a day		
	Beyond 150 days	Nothing		
POSTHOSPITAL SKILLED NURSING CARE... In a facility approved by Medicare, you must have been in a hospital for at least three days and enter the facility within 30 days after hospital discharge	First 20 days	100% of costs		
	Additional 80 days	All but $61.50 a day		
	Beyond 100 days	Nothing		
MEDICAL EXPENSE	Physician services inpatient and outpatient medical services and supplies at a hospital, physical and speech therapy and ambulance	80% of reasonable charge (after $75 deductible)	20% of Medicare allowable charges (after a $200 annual deductible)	All other charges

WARNING

If you understand Big Five Features #s 3-5 from Chapter 4 and if the information on the outline is straightforward, you should be able to tell which features the policy has.

But even people who know what to look for cannot always understand how much a policy pays on doctor bills from reading the outline of coverage. In addition, insurance agents are sometimes mistaken about how much a policy pays on doctor bills.

So if you do not understand what the outline of coverage says about doctor bills, you should do the following:

(1) See if the policy is in Chapter 5. If it is, rely on our explanation of what the policy pays on doctor bills.

(2) If your policy is only listed in Chapter 6 (a few policies are listed in both Chapters 5 and 6), you will not know how much it pays on excess charges. To find out, call the **state insurance department** actuarial section in Nashville at **(615) 741-2825.** Have the outline of coverage with you when you call. The person who answers will ask you a few questions and then call you back to give you the information you need.

(3) If it is a policy that is not in either Chapter 5 or Chapter 6, you may not understand how much it pays on doctor bills at all. In that case, follow the instructions above for calling the state insurance department.

A HINT ON HOW TO FIND BIG FIVE FEATURE #5

A policy may have a yearly limit on what it will pay on doctor bills but not show it on the chart. If you do not find a yearly limit on the chart, you should look for a limit somewhere else on the outline. It may be under "limitations and exclusions" or "what this policy does not cover," or it may be in a note under the chart.

How to Find Extra Features in an Outline of Coverage

Once you know which of the Big Five features a policy has, you may also want to know what extra (non-Big Five) features it has.

When Does the Policy Begin to Cover Pre-existing Conditions?

To find out when the policy begins to cover pre-existing conditions, look under "exclusions and limitations" or "what this policy does not cover" or any other heading that means the same thing. There it may or may not say something about pre-existing conditions. If it does not, you may have to wait to see the policy itself to know for sure. If your policy is listed in Chapter 8 under **Pre-existing Condition Limitations**, then you can look there to find out how long you have to wait until pre-existing conditions are covered. (Also look in Chapter 8 in the same section to find out more about pre-existing conditions in general.)

Does the Policy Cover Prescription Drugs, Private Duty Nurse, Intermediate Care, Custodial Care, and/or Other Non-Big Five Features?

(1) Look on the outline in the list of what the policy does not cover. This list usually comes after the chart.

(2) If you do not see the feature you are looking for in the list, look over the rest of the outline, including the chart.

(3) Read carefully to find out how much of your costs will be paid and under what conditions. (Our Appendix IV shows the policies that cover prescription drugs. But check the outline or ask the insurance agent to be sure that a prescription drug benefit is still part of the policy. You should also find out if the limits or how much it pays have changed.)

Comparing the Policies

When you are finished, you should be able to decide which policy you want to apply for by comparing your notes. If you have more than a few policies to choose from, you may want to make a chart so you can compare the policies more easily. The chart should have rows for all the policies you are choosing from and columns for price and for all the benefits you think are the most important.

READING THE POLICY ITSELF DURING THE FREE LOOK

Don't Let Your "Free Look" Go by Without Reading the Policy

After the agent brings your actual policy, the law gives you a ten day **"free look"** period during which you can change your mind for any reason and get a full refund of the premium by returning the policy. Some policies give you 30 days for a "free look". The "free look" begins the day the agent brings the policy to you. It is important to read the policy and to decide during the "free look" whether you want to keep the policy. If you wait until after the free look period to return the policy to the insurance company, you probably will not be able to get your money back.

Be sure to read the policy during this free look period since the policy, not the outline of coverage nor the agent's promises, is the legal contract that the insurance company must go by. Make sure you are getting what you thought you'd get when you read the outline.

Read these Parts Closely

Pay special attention to the sections on **"medical expense coverage," "definitions,"** and **"limitations and exclusions,"** (sometimes called "This policy does not cover:").

These Parts Can Wait

Certain sections are required to be basically the same in all health policies in Tennessee. You need to read these sections, but you do not need to go over them during your free look period:

- Entire Contract /Changes
- Time Limit on Certain Defenses
- Grace Period
- Reinstatement
- Notice of Claim
- Claim Forms
- Proofs of Loss

CHAPTER 8: IF YOU ALREADY HAVE MENTAL OR PHYSICAL HEALTH PROBLEMS

How This Chapter Can Help You

If you have problems with your health before you take out a Medicare Supplement policy, you need to understand how "pre-existing condition limitations" work. You may also need to know what to do if you are turned down for insurance because of your health. If you have a mental illness or a drug or alcohol problem or if you are afraid you will have these problems in the future, you need to know that certain policies limit or deny payment for these conditions. Finally, if you are younger than age 65, but you have Medicare because of a disability, you need to know which Medicare Supplement policies will consider your application. This chapter gives you the infomation you need to have the best chance of getting insurance coverage in these situations.

Pre-Existing Condition Limitations

How They Work

From the first day you take out the policy, a Medicare Supplement policy must cover any "new" health problems that develop after you become insured. But, under the law, a policy can refuse to pay for treatment you receive for "pre-existing" health problems during the first six months you have the policy. In other words, the policy can have a "waiting period" of up to six months before it will cover certain illnesses you had before you got the policy. This is called a "pre-existing condition limitation." After the first six months any Medicare Supplement policy will have to cover pre-existing health problems just like it covers new health problems.

Is Your Illness a "Pre-Existing Condition"?

It is important to understand your policy's pre-existing condition limitation. Some people have failed to file claims for treatment of illnesses that they mistakenly thought were pre-existing conditions.

The policy must say what the insurance company means when it uses the term "pre-existing condition". Usually, the definition refers to any health problems for which your doctor treated you, gave advice, or recommended treatment during the six months before you took out the policy. In a Medicare Supplement policy, the definition of a pre-existing condition cannot consider what happened to your health more than 6 months before you became insured.

Here's an example. You buy a Medicare Supplement policy which has a "waiting period" of six months before it will cover treatment of a pre-existing conditon.

Your policy says a health problem is a pre-existing condition if you were treated for it by a doctor during the 6 months before you bought the policy. Two months after you become insured (during the "waiting period"), you have a gall stone attack. Your application for the policy told the company that you had had gall stone trouble 10 months before you took out your policy. You did not go to your doctor or take medicine and your doctor did not advise any more treatment for gall stones during the 8 months before you got your policy. Should you file a claim for the current treatment of your gall bladder? The answer is "yes". Your gall stones are not a pre-existing condition for this policy since you were not treated for them during the six months before you became insured.

Here's What to do

If you are not so lucky as the person in our example, you may have health problems for which you are still being treated at the time you want to buy a policy or change policies. If you are worried about needing insurance coverage for these health problems soon after you get the policy, we have two suggestions:

(1) **Try to get a Medicare Supplement Policy which has no waiting period or has a shorter waiting period before it will cover pre-existing conditons.** The individual (non-group) policies which do this are listed below, with their waiting period shown. Sometimes the shorter waiting period is a feature you can add to the basic policy by paying a one-time fee. Where this is true, we show it by saying the policy has a "rider". Some group policies not shown here may also have a shorter waiting period.

Acceleration Life Ins. Co.
Form # AMSP - 511 with rider
No wait

American General Life & Acc. Ins. Co.
Form #s 6001 M-1 and # 6001 M-2
If you are replacing another Medicare Supplement policy, the 6-month wait for coverage of pre-existing conditions by this policy begins on the date you got your original policy (i.e., no new wait).

American Integrity Ins. Co.
Form #s MMS-84-P and MS-85-P
90 day wait

Associated Doctors Health & Life Ins. Co.
Form # MCS-350 and # MCS-359
2 mo. wait

Atlantic American Life Ins. Co.
Form # MS 2083 with rider
If approved by company,
31 day wait

Banker's Life & Casualty Co.
Form # CR-93T and GR-75R
60 day wait

Benefit Trust Life Ins. Co.
Form # MSP-182
45 day wait

Business Men's Assurance Co. of America
Form # D 7054
If you name the condition in the applicaition, no wait

Central Security Life Ins. Co.
Form # 8683 Rev. 4/83 with rider
2 mo. wait

Central States Health & Life Co. of Omaha
Form # 286
No wait

Certified Life Ins. Co.
Form # CER-900
30 day wait

Continental Bankers Life Ins. Co. of the South
Form # GRMS 8/85 (TN) REV
90 day wait
Form # SMS 10/85
60 day wait

Continental General Ins. Co.
Form # 314
60 day wait

Continental Life Ins. Co.
Form # SC-85 with rider
31 day wait

Gerber Life Ins. Co.
Form #s MSA2-830, MSA4-830, MSA6-830, and MSA10-830
3 mo. wait

Globe Life and Accident Ins. Co.
Form # MCP-4
60 day wait

Golden Rule Ins. Co.
Form#s GR1-H-2.1 and GR1-H-2.1P
If you name the condition on the application and the company approves, no wait

Guarantee Trust Life Ins. Co.
Form # 85420 with rider
90 day wait

Gulf Life Ins. Co.
Form #s MED-1(1-85) and MED-2 (1-86) with rider
If you are replacing a Medicare Supplement policy from another company, no wait

Hermitage Health and Life Ins. Co.
Form #807-84
60 day wait

Orange State Life & Health Ins. Co.
Form # 0S872 with rider
30 day wait

Physicians Mutual Ins. Co.
Form #s P192 and P393C
No wait

Pioneer Life Ins. Co. of Illinois
Form # 8940 with rider
3 mo. wait

Pyramid Life Ins. Co., The
Form #s H-91-G and H-92-G
No wait
Form # H-94
90 day wait

Standard Life & Acc. Ins. Co.
Form # 1223-186
90 day wait

Statesman National Life Ins. Co.
Form #s P-193 and P-220 with rider
1 mo. wait

Union Casualty Co.
Form # 509
3 mo. wait

United American Ins. Co.
Form#s MC-7, MAXC, MAXC+, DMXC with rider R-PECL-A, and DMXC+
60 day wait

(2) **If you already have health insurance, decide if you can afford to keep the "old" insurance until the end of the waiting period for pre-existing conditions in the new policy.** Tennessee law now allows you to buy a Medicare Supplement policy six months before you become eligible for Medicare. Some people do this while still covered under an employer group insurance plan. By the time they get Medicare and lose the group coverage, they have passed the new policy's waiting period for pre-existing conditions.

If neither of our two suggestions work for you, you may have to rely on Medicare alone to pay for treatment of your pre-existing health problems during the first six months on your new policy. Be sure to read the section, Making the Most of Your Medicare Benefits in Chapter 2. If you were planning to change policies, think carefully about whether the new policy is worth the risk that you will have to pay whatever Medicare doesn't pay for treatment of your pre-existing conditions during the first six months.

What to do if you are Turned Down for Health Reasons

Open Enrollment

If you are turned down for a policy because of poor health, you may want to apply for a policy which is sold only during certain months of the year--the "open enrollment" period. You will have to answer a few health questions on the application. But these questions will be less detailed than what many other policy applications ask. We know of only two insurance companies in Tennessee which have Medicare Supplement policies with open enrollment periods. They are Blue Cross & Blue Shield of Tennessee, which sells three "Blue Cross 65" contracts and Memphis Hospital Service & Surgical Assn. which sells "Blue Cross & Blue Shield 65". (See Appendix II for addresses and phone numbers.)

Guaranteed Acceptance Policies

Another way to get insurance in spite of health problems is to buy a "guaranteed acceptance" or "guaranteed issue" policy. Organizations such as the American Association of Retired Persons (AARP) and the Older Women's League (OWL) have group Medicare Supplement policies which accept any member of the organization who is over age 65. An insurance agent may also be able to help you find an individual (non-group) Medicare Supplement policy which is issued to everyone who applies. In some cases, you will have to pay more for a guaranteed issue policy.

"Insurance Pool"

You may be able to get insurance through the "health insurance pool for uninsurables" which is to be set up by the state insurance department by July 1, 1987, at the latest. Insurance through the "pool" may cost as much as one and one-half times the price of standard coverage. To find out more, call the Tennessee Department of Commerce and Insurance.

Try These Policies if you are Under age 65

If you have Medicare because of a disability but you are not yet 64 1/2 years old, most Medicare Supplement policies will not accept you. Following this paragraph is a list of companies that will consider your application; they may or may not accept you for coverage. You will probably have to pay a higher price for the policy than you would if you were over 65. After some of these policy form numbers you will find "See Chapter 5". This means it is a policy that has all "The Big Five" features and is described more fully in Chapter 5. One policy is in Chapter 6 and this is shown as "See Chapter 6."

American Income Life Ins. Co.
Form # H41000
(See Chapter 5)

American National Ins. Co.
Form # GMS-3
(See Chapter 5)

Associated Doctors Health & Life Ins. Co.
Form # MCS-359
(See Chapter 6)

Georgia Life & Health Ins. Co.
Form #s MS100(86)T and MC85(T)
(See Chapter 5 for more on Form # MS100 (85)T)

Horace Mann Cos., The
Form # GC-M1509X

Memphis Hospital Service &Surgical
Assn., Inc.
Form # BC-BS-65

National States Ins. Co.
Form #s SBB and UMS-1
(See Chapter 5 for more on UMS-1)

Orange State Life & Health Ins. Co.
Form # OS872
(See Chapter 5)

Union Casualty Co.
Form #509

United American Ins. Co.
Form # DMXC

World Ins. Co.
Form A2485

When you reach age 65, you may be able to get a better and/or a cheaper Medicare Supplement policy than you got as a disabled person at a younger age. You should at least compare your policy to several "guaranteed acceptance" policies (see above).

Try These Policies if you Have Mental or Emotional Problems or a Drug or Alcohol Problem

As you can see from our discussion in Chapter 1 (under WHAT PART A DOES NOT PAY FOR and WHAT PART B DOES NOT PAY FOR), Medicare puts severe limits on what it will pay for psychiatric treatment. The law allows Medicare Supplement policies to be even more limited than Medicare in what they will pay for the treatment of mental or emotional and drug or alcohol abuse problems. **The following policies have no additional limitations beyond Medicare's limitations on psychiatric treatment.**

Acceleration Life Ins. Co.
Form # AMSP-511

American Integrity Ins. Co.
Form # MMS-84-P and MS-85-P

Atlantic American Life Ins. Co.
Form # MS2083 with 2 different riders

Bankers Life and Casualty Co.
Form #s CR-93T and GR-75R

Blue Cross & Blue Shield of Tennessee
Form #s 65 Premium Contract and Prudent Purchaser Contract

Business Men's Assurance Co. of America
Form # 7054

Central National Life Ins. of Omaha
Form # C-10-004TN

Central States Health & Life Co. of Omaha
Form # 286

Continental Casualty Co. (CNA)
Form # P1-67720-A, Plans 1 and 2

Continental General Ins. Co.
Form #314

Empire Life Ins. Co.
Form # EMP 500-7

Federal Home Life Ins. Co.
Form #s 4535-A(S) and NAC-9777

First United Life Ins. Co.
Form #MS-1

Georgia Life & Health Ins. Co.
Form #s MS-100 (86)T and MC85 (T)

Gerber Life Ins. Co.
Form #s MSA2-830, MSA4-830, MSA6-830, and MSA10-830

Golden Rule Ins. Co.
Form #s GR1-H-2.1 and GR1-H-2.1P

Guarantee Reserve Life Ins. Co.
Form #s 8015 and 8016

Guarantee Trust Life Ins. Co.
Form # 85420

Gulf Life Ins. Co.
Form #s MED-1 and MED-2

Horace Mann Cos., The
Form # GC-M1509X

Inter-Ocean Ins. Co.
Form # 3166-IN

Liberty National Life Ins. Co.
Form #s 7038 and 7041

Life Ins. Co. of Cincinnati
Form # LI-1588, ;LI-1590-1, and LI-1590-1 A

Montgomery Ward Life Ins. Co.
Form # 110-370, Plans 1, 2, and 3

Mutual of Omaha Ins. Co.
Form #s M2, M4, M101, Series 13852

Mutual Protective Ins. Co.
Form #s MP397, MP497, MP486Y, MP486Z, MP486X , 3985, and 3995

National Casualty Co.
Form # 8427RU

National Health Ins. Co.
Form # MSI and MSII

New Century Life
Form # NCL-MS-TN

New York Life Ins. Co.
Form # 8145-1

Old American Ins. Co.
Form #s ID3084, ID3085, and ID3087

Orange State Life & Health Ins. Co.
Form # OS472

Physicians Mutual Ins. Co.
Form # P192 and P393C

Pioneer Life Ins. Co. of Ill.
Form # 8940

Preferred Risk Life Ins. Co.
Form #L5223

Pyramid Life Ins. Co., The
Form #s H-91-G, H-92-G, and H-94

Standard Life & Accident Ins. Co.
Form # 1223-186

State Farm Mutual Automobile Ins. Co.
Form # 97033B

Statesman National Life Ins. Co.
Form #s P-220 and P-193

Time Ins. Co.
Form # 680

Union Bankers Ins. Co.
Form # 76M

Union Casualty co.
Form # 509

United American Ins. Co.
Form # DMXC

World Ins. Co.
Form # A2485

CHAPTER 9: WHERE TO GO FOR HELP

The **Tennessee Department of Commerce and Insurance** can help with many insurance problems.**In Tennessee call toll-free 1-800-342-9029 ; In Davidson County, call 741-2218.** See Appendix I for the addresses of local offices.

There are a number of legal services programs, and legal care programs in Tennessee which may be able to help you. with problems involving Medicare or insurance. Some of these programs have income eligibility guidelines and some do not.

These programs are:

WEST TENNESSEE

Legal Care For Senior Citizens
296 Washington Avenue
Memphis, TN 38103
(901) 523-1736

Memphis Area Legal Services, Inc.
161 Jefferson, Suite 1100
Memphis, TN 38103-2363
(901) 526-5132

Branch Office:

111 N. Maple Street
Covington, TN 38019-2199
(901) 525-1314

West Tennessee Legal Services, Inc./
Senior Citizens Law Project
210 West Main Street
P.O. Box 2066
Jackson, TN 38301
(901) 423-0616

Branch Office

208 South Church
P.O. Box 366
Dyersburg, TN 38024
(901) 285-8181

113 West Paris
P.O. Box 787
Huntingdon, TN 38344

141 North 3rd Street
P.O. Box 189
Selmer, TN 38375
(901) 645-7691

MIDDLE TENNESSEE

Legal Services of Middle Tennessee, Inc.
800 Stahlman Building
211 Union Street
Nashville, TN 37201
(615) 244-6610

Branch Offices:

111 South 2nd Street
Clarksville, TN 37040
552-6656 (Montgomery County)
1-800-342-3317 (Stewart, Houston, Humphrey, Robertson, Cheatham, Dickson Counties)

650 North Water Avenue
Gallatin, TN 37066
451-1880 (Sumner and Trousdale Counties)
444-5221 (Wilson County)

304 East Vine Street
Murfreeesboro, TN 37130
890-0905 (Rutherford and Cannon Counties)
244-5612 (Williamson County)

Legal Services For the Elderly
606 Lee Avenue
Fayetteville, TN 37334
(615) 433-7182

Legal Services of South Central Tennessee
P.O. Box 1256
Columbia, TN 38401
(615) 381-5533

Branch Office:

P.O. Box 129
Tullahoma, TN 37388
(615) 455-7000

EAST TENNESSEE

Knoxville Legal Aid Society and Legal
Services for the Elderly
502 South Gay St., Suite 404
Knoxville, TN 37902
(615) 974-5241

Legal Referral Services for Over Sixty
P.O. Box 11428
Knoxville, TN 37939
(615) 691-2551

Legal Services of Upper East Tennessee, Inc.
and Legal Care for Older People
311 West Walnut Street
Johnson City, TN 37601
(615) 928-8311

Branch Office:

1001 West 2nd North Street
Morristown, TN 37814
(615) 587-4850

Rural Legal Services of Tennessee, Inc.
P.O. Box 3358
Oak Ridge, TN 37831
(615) 483-8454

Branch Office:

Arcade Bldg. Courthouse Sq.
Cookeville, TN 38501
(615) 528-7436

Upper Cumberland Legal Services
for the Elderly
1225 Burgess Falls Road
Cookeville, TN 38501
(615) 432-4111

Southeast Tennessee Legal Services, Inc.
540 McCallie Avenue, Suite 400
Chattanooga, TN 37402
(615) 756-4013

Branch Office:
P.O. Box 306
Cleveland, TN 37311
(615) 479-8577
Toll free number in Rhea, Bledsoe,
Sequatchie, and Marion Counties:
1-800-572-7457

Here are more offices that help people in nursing homes and other facilities:

WEST TENNESSEE

Long Term Care Ombudsperson
N.W. TN Development District
P.O. Box 963
Martin, TN 38237
(901) 587-4213

MIDDLE AND EAST TENNESSEE

Long Term Care Ombudsperson
South Central Tennessee Development
District
815 South Main Street
P.O. Box 1346
Columbia, TN 38402-1346
(615) 381-2040

Long Term Care Ombudsperson
Mid-Cumberland Human Resource Agency
Metroplex Drive, Suite 200
Corporate Park, Bldg. D.
Nashville, TN 37211
(615) 331-6033

Advocacy Assistance Coordinator/
Upper Cumberland District
1225 Burgess Falls Road
Cookeville, TN 38501
(615) 432-4111

Long Term Care Ombudsperson
Family & Children's Services of
Chattanooga
1100 Gateway Ave., Suite 1302
Chattanooga, TN 37402
(615) 755-2870

Long Term Care Ombudsman
East Tennessee Human Resource Agency
P.O. Box 11428
Knoxville, TN 37939
(615) 691-2551
1-800-362-9276

APPENDIX I: GENERAL INSURANCE TIPS

Don't be Fooled by Misleading Agents or Advertising

Beware of an agent who says the policy pays for "everything" or pays something different from what is written in the policy itself. Read the policy carefully when you get it. If there is a difference between what the agent, or the outline of coverage says and what the policy says, the company only has to go by what is written in the policy.

You should read very carefully any advertising which implies a connection with Medicare, Social Security, or other government programs. At least two insurance companies have sent advertising material through the mail that looks like a notice from a government program such as Social Security, Medicare, or the Veterans Administration. Some people have mistakenly thought their government benefits would be affected if they did not send an answer back by the date given in the notice. Others thought they were signing up for coverage sponsored by the federal governement when it was actually life or health insurance offered by a private business. The federal governement does not sponsor individual health or life insurance.

Be Sure the Insurance Application Form has the Correct Information

Carefully read over the insurance application form after you have filled it out but before you sign it. If you have left out information or if you have given false information, you might have a problem collecting benefits later.

Do Not pay Cash

Never pay cash for any policy or make out a check in the agent's name. It is best to use a check or money order made payable to the insurance company.

Keep a Copy of Your Insurance Policy in a Safe Place

It is a good idea to choose someone ahead of time who will handle your affairs if you become seriously ill. This person should know where all your records are kept, including your insurance policies.

Do Not Wait for the Company to Bill you for the Premium

You are responsible for making sure that you pay your premium to the company on time. Many companies send you a bill as a courtesy, but if they fail to do it, and you do not pay on time, you may find the company has dropped you from its rolls because of non-payment. The company then has three choices. It may refuse any further coverage. It may reinstate the coverage. It may sell you a new policy which may have a higher premium, may have a pre-existing condition waiting period, and which will not pay bills you had between the time your old policy ended and your new one began. To avoid this, mark your calendar to remind yourself to pay the premium when due.

You Don't Have to Take "No" for an Answer

If an insurance company will not pay a claim or make a refund when you believe it should, let the company know you are unhappy. If the company still refuses to pay, you may want to send your complaint to the Tennessee Department of Commerce and Insurance at one of the offices listed on this page. If the company is one they regulate and their staff finds you are right, they will contact the company for you. You may also contact the Department about an insurance agent who tries to mislead you.

Tennessee Dept. of Insurance Statewide Toll-Free Number 1-800-342-4029 (In Davidson County Call 741-2218)

Offices of the Tennessee Department of Commerce and Insurance:

1808 West End Bldg.
12th Floor
Nashville, TN 37219

203 State Office Bldg.
Knoxville, TN 37902

170 North Main Street
Memphis, TN 38103

207 Boone Street North
Johnson City, TN 37601

540 McCallie Avenue, Suite 214
Chattanooga, TN 37402-2056

Room 405A
Box 45
Lowell Thomas State Office Bldg.
Jackson, TN 38301

You might also get help from a lawyer about an unpaid claim or refund. If your claim is under $10,000 you could sue the insurance company in General Sessions Court.

APPENDIX II: INDEX OF COMPANIES AND MEDICARE SUPPLEMENT POLICIES

Most of the policies in this list are individual Medicare Supplement policies which have been approved for sale by the Tennessee Department of Commerce and Insurance. Group policies that are mentioned in this book are also listed,although they are not regulated like the individual policies are under Tennessee law.

The form number of each policy follows the name and address of the insurance company that sells the policy. The page numbers show you where we talk about the policy in this book.

To find out more about a particular policy, check your local phone book to see if the company has a local office. Otherwise, call a local independent insurance agent who sells health insurance or contact the company at their home office, which is given below.

1. **ACCELERATION LIFE INS. CO.**
   5400 N. High Street
   Columbus, OH 43214
   (614) 888-4007
   Form # AMSP-511
   Pages 100,103

2. **AMERICAN ASSOCIATION OF RETIRED PERSONS(AARP)**
   Prudential Insurance Co. of America, The
   P.O. Box 13999
   Philadelphia, PA 19187-0721
   1-800-492-2024
   Four Medicare Supplement policies
   (Group policy sold only to members of
   AARP) Pages 33, 41, 102

3. **AMERICAN GENERAL LIFE & ACCIDENT INS. CO.**
   American General Center-Nashville
   Nashville, TN 37250
   (615) 749-1000
   Form #s 6001 M-1 and 6001 M-2
   Pages 46, 84, 87, 88, 100

4. **AMERICAN INCOME LIFE INS. CO.**
   P.O. Box 208
   Waco, TX 76797
   (817) 772-3050 or 1-800-433-3405
   Form #s H41000 and H42000
   Pages 47, 82, 89 , 100,103

5. **AMERICAN INTEGRITY INS. CO.**
   2 Penn Center Plaza
   Philadelphia, PA 19102-1797
   (215) 561-1400
   Form #s MMS-84-P, Plan V; SS-65; and
   MS-85-P, Pages 39, 48, 83, 100, 103

6. **AMERICAN NATIONAL INS. CO.**
   1 Moody Plaza
   Galveston, TX 77550-7999
   (409) 766-6495
   Form # GMS-3
   Pages 49, 84, 88, 90, 103

7. **AMERICAN REPUBLIC INS. CO.**
   National Headquarters
   Des Moines, IA 50334
   (515) 245-2000
   Form #s A-2400 TN-1-82
   Page 90

8. **ASSOCIATED DOCTORS HEALTH & LIFE INS. CO.**
   P.O. Box 10487
   Birmingham, AL 35289
   1-800-633-6572
   Form #s MCS-350 and MCS-359
   Pages 87,100,103

9. **ATLANTIC AMERICAN LIFE INS.CO.**
   4370 Peachtree Road, N.E.
   P.O. Box 10075
   Atlanta, GA 30319-0075
   (404) 266-5500
   Form # MS 2083
   Pages 50, 82, 100, 103

10. **BANKERS LIFE AND CASUALTY CO.**
4444 West Lawrence Avenue
Chicago, IL 60630
(312) 777-7000
Forms #s GR-75R and CR-93T
Pages 51, 84, 89, 100, 103

11. **BENEFIT TRUST LIFE INS. CO.**
Benefit Trust Life Bldg.
1771 Howard Street
Chicago, IL 60626
(312) 274-8100
Form # MSP-182
Pages 100,116

12. **BLUE CROSS/BLUE SHIELD OF TENNESSEE**
Chattanooga, TN 37402
1-800-821-1000
Form #s Blue Cross 65 Contract;
65 Premium Contract; 65 Prudent
Purchaser, Pages 102, 103, 116

13. **BUSINESS MEN'S ASSURANCE CO. OF AMERICA**
BMA Tower
One Penn Valley Park
Kansas City, MO 64141
(816) 753-8000
Form # D 7054
Pages 100, 104

14. **CENTRAL NATIONAL LIFE INS. CO. OF OMAHA**
c/o Eagle Life Ins. Co.
P.O. Box 32565
San Antonio, TX 78284
(512) 344-3024
Form # C-10-004-TN
Pages 104, 116

15. **CENTRAL SECURITY LIFE INS. CO.**
P.O. Box 2488
Ft. Worth, TX 76113-2488
National 1-800-433-2180
Texas 1-800-772-2840
Local (817) 732-2222
Form # 8683 Rev. 4/83
Pages 52, 53, 84, 89, 100

16. **CENTRAL STATES HEALTH & LIFE CO. OF OMAHA**
Western at 96th
P.O. Box 34350
Omaha, NE 68134-0350
(402) 397-1111
Form # 286
Pages 101, 104

17. **CERTIFIED LIFE INS. CO.**
14724 Ventura Boulevard
Sherman Oaks, CA 91403
(818) 981-9000
Form # CER-900
Page 101

18. **CONTINENTAL AMERICAN LIFE INS. CO.**
P.O. Box 15750
Wilmington, DE 19850
(302) 454-5043
Form # MS-1

19. **CONTINENTAL BANKERS LIFE INS CO. OF THE SOUTH**
P.O. Box 809008
Dallas, TX 75380-9008
(214) 934-3332
Form #s SMS 10/85 and
GRMS 8/85 (TN) REV, Plan 3
Pages 54, 84, 86, 101, 116

20. **CONTINENTAL CASUALTY CO. (CNA)**
CNA Plaza
Chicago, IL 60685
(312) 822-4241
Form # P1-67720-A, Plans 1 and 2
Pages 55, 83, 87, 91, 104

21. **CONTINENTAL GENERAL INS. CO.**
8901 Indian Hills Drive
Omaha, NE 68114
(402) 397-3200
Form # 314
Pages 101, 104, 116

22. **CONTINENTAL LIFE INS. CO.**
3709 Nolensville Road
Nashville, TN 37211
(615) 834-8000
Form # SC-85
Pages 56, 84, 91, 101

23. **EMPIRE LIFE INS. CO.**
2424 S. 130th Circle
Omaha, NE 68144
(402) 330-3800
Form # EMP 500-7
Page 104

24. **FEDERAL HOME LIFE INS. CO.**
78 W. Michigan Mall
Battle Creek, MI 49017
(616) 968-5500
Form #s 4535-A(S) and NAC-9777
Page 104

25. **FIRST NATIONAL LIFE INS. CO.**
7 Clayton Street
Montgomery, AL 36104-4089
(205) 832-1850
Form # MS-183, Options 1,2, and 3
Pages 57, 82

26. **FIRST UNITED LIFE INS. CO.**
c/o Life Shares Service Co.
P.O. Box 81209
Lincoln, NE 68501
1-800-228-0269
Form # MS-1
Pages 58, 59, 83, 104, 116

27. **GEORGIA LIFE & HEALTH INS.CO.**
P.O. Box 1676
Atlanta, GA 30301
(404) 763-4545
Form #s MS100 (86)T and MC85 (T)
Pages 60, 83, 103, 104

28. **GERBER LIFE INS. CO.**
66 Church Street
White Plains, NY 10601
(914) 761-4404
Form #s MSA2-830; MSA4-830;
MSA6-830 and MSA10-830
Pages 101, 104

29. **GLOBE LIFE AND ACCIDENT INS. CO.**
Globe Life Center
120 Robert S. Kerr Avenue
Oklahoma City, OK 73184
(405) 270-1400
Form #s MCP-3 and MCP-4
Pages 39, 101

30. **GOLDEN RULE INS. CO.**
Golden Rule Buildings
The Waterfront
Indianapolis, IN 46224-4199
(317) 297-4123
Form #s GR1-H-2.1P and GR1-H-2.1
Pages 101, 104, 117

31. **GUARANTEE RESERVE LIFE INS. CO.**
530 River Oaks West
Calumet City, IL 60409
(312) 375-7800
Form #s 8015 and 8016
Pages 86, 101, 104

32. **GUARANTEE TRUST LIFE INS. CO.**
1275 Milwaukee Avenue
Glenview, Il 60025
(312) 699-0600
Form # 85420
Pages 101, 104

33. **GULF LIFE INS. CO.**
1301 Gulf Life Drive
Jacksonville, FL 32207
(904) 390-7154
Form #s MED-1 and MED-2
Pages 61, 84, 87, 89, 101, 104

34. **HERMITAGE HEALTH AND LIFE INS. CO.**
One Hermitage Plaza
P.O. Box 2200
Franklin, TN 37065-2200
(615) 794-8100
Form # 807-84
Pages 62, 63, 83, 101

35. **HORACE MANN COMPANIES, THE**
1 Horace Mann Plaza
Springfield, IL 62715
(217) 789-2500
Form # GC-M1509X
Pages 103, 104

36. **INTER-OCEAN INS. CO.**
Cincinnati Financial Center
P.O. Box 145497
Cincinnati, OH 45214-5497
(513) 782-1481
Form 3166-IN
Page 104

37. **LIBERTY NATIONAL LIFE INS. CO.**
P.O. Box 2612
Birmingham, AL 35202
(205) 325-2722
Form #s 7055; 7041; 7038
Pages 39, 64, 83, 90, 104

38. **LIFE INS. CO. OF CINCINNATI**
P.O. Box 145496
Cincinnati, OH 45214-5496
(513) 771-2000
Form#s LI-1588; LI-1590-1; and
LI-1590-1-A, Page 104

39. **MEMPHIS HOSPITAL SERVICE & SURGICAL ASSOCIATION, INC.**
85 North Danny Thomas Boulevard
Memphis, TN 38101
(901) 529-3111
Form # BC-BS-65
Pages 102, 103

40. **MONTGOMERY WARD INS.**
200 North Martingale Road
Schaumburg, IL 60194
1-800-621-0393
Form # 110-370 Plans 1, 2, and 3
Page 104

41. **MUTUAL OF OMAHA INS. CO.**
Mutual of Omaha Plaza
Omaha, NE 68175
(402) 342-7600
Form #s M2; M4; and M101
Page 104

42. **MUTUAL PROTECTIVE INS. CO.**
Medico Life Ins. Co.
4625 Farnam Street
Omaha, NE 68132-3299
(402) 551-6900
Form #s MP 397; MP 497; MP 486X;
MP 486Y; MP 486Z; MP3985; and
MP3995, Page 104

43. **NATIONAL CASUALTY CO.**
P.O. Box 463
Southfield, MI 48037
(314) 652-1414
Form # 8427RU
Pages 65, 84, 104

44. **NATIONAL HEALTH INS. CO.**
P.O. Box 619999
Dallas/Ft. Worth Airport
TX 75261-9999
(817) 640-1900
Form #s MSI and MSII
Pages 88, 104

45. **NATIONAL SENIOR CITIZENS GROUP INSURANCE TRUST**
Union Fidelity Life Ins. Co.
National Executive Offices
Trevose, PA 19048-0001
1-800-523-5758
Page 33

46. **NATIONAL STATES INS. CO.**
11433 Olde Cabin Road
St. Louis, MO 63141
(314) 997-1191
Form #s SBB and UMS-1
Pages 66, 83, 103, 117

47. **NATIONWIDE MUTUAL INS. CO.**
One Nationwide Plaza
Columbus, OH 43216
(614) 227-7111
Form# 1522
Page 89

48. **NEW CENTURY LIFE**
P.O. Box 24357
Nashville, TN 37202
(615) 327-9551
Form # NCL-MS-TN
Page 104

49. **NEW YORK LIFE INS. CO.**
51 Madison Avenue
New York, NY 10010
(212) 576-7000
Form # 8145-1
Pages 67, 84, 89, 90, 104

50. **OLD AMERICAN INS. CO.**
4900 Oak Street
P.O. Box 573
Kansas City, MO 64141
(816) 753-4900
Form #s ID3084; ID3085; and ID3087
Page 104

51. **OLDER WOMEN'S LEAGUE (OWL)**
Towers Administrator
342 Madison Avenue
New York, NY 10017
1-800-223-1481
(Group policy sold only to members of the Older Womens League)
Pages 41, 102

52. **ORANGE STATE LIFE & HEALTH INS. CO.**
2400 West Bay Drive
Largo, FL 33540
(813) 586-3733; (800) 237-9726
Form #s OS472 and OS872
Pages 68, 69, 83, 101, 103, 104

53. **PHYSICIANS MUTUAL INS. CO.**
42nd & Dodge
Omaha, NE 68131
(402) 556-8900
Form #s P192 and P393C
Pages 70, 71, 72, 73, 82, 83, 90, 101, 104

54. **PIONEER LIFE INS. CO. OF ILLINOIS**
304 North Main Street
Rockford, IL 61101
(815) 987-5000
Form # 8940
Pages 74, 84, 101

55. **PREFERRED RISK LIFE INS. CO.**
1111 Ashworth Road
W. Des Moines, IA 50265
(515) 225-5337
Form # L5223
Pages 91, 104

56. **PROFESSIONAL INS. CORP.**
P.O. Box 1410
Jacksonville, FL 32231
(904) 354-7171
Form # MS-81, Plan B

57. **PYRAMID LIFE INS. CO., THE**
6201 Johnson Dr.
Shawnee Mission, KS 66202
(913) 722-1110
Form #s H-91-G; H-92-G; H-94
Pages 75, 84, 90, 101, 104, 117

58. **RESERVE LIFE INS. CO.**
P.O. Box 660254
Dallas, TX 75266-0254
(214) 670-9700
Form # PMS86
Pages 76, 84

59. **RESERVE NATIONAL INS. CO.**
6100 North Grand Boulevard
Oklahoma City, OK 73118
(405) 848-7931
Form # MCS-82, Plans 1, 2, and 3
Pages 77, 88

60. **SECURE CARE 65**
National Home Life Assurance
Valley Forge, PA 19494
1-800-523-7900
(Group policy)
Page 33

61. **SOUTHLAND LIFE INS. CO.**
P.O. Box 2220
Dallas, TX 75221
(214) 922-1200
Forms #s 12589-84 and 12590-84
Page 90

62. **SOUTHWESTERN GENERAL LIFE INS. CO.**
P.O. Box 4287
Macon, GA 31297-4287
(912) 741-2500
Form #s 8140A and 8141A
Pages 87, 88

63. **STANDARD LIFE & ACCIDENT INS. CO.**
P.O. Box 25097
Oklahoma City, OK 73193
(405) 232-5281
Form # 1223-186
Pages 78, 83, 101, 104

64. **STATE FARM MUTUAL AUTOMOBILE INS. CO.**
One State Farm Plaza
Bloomington, IL 61701
(309) 766-2311
Form # 97033B
Page 104

65. **STATESMAN LIFE INS. CO.**
P.O. Box 1886
Birmingham, AL 35201
(205) 942-2011
Form # MS-219
Page 117

66. **STATESMAN NATIONAL LIFE INS. CO.**
3815 Montrose Boulevard
Houston, TX 77006
(800) 231-6331
Form #s P-220 and P-193
Pages 79, 83, 86, 101, 104, 117

67. **TIME INS. CO.**
P.O. Box 624
Milwaukee, WI 53201
(414) 271-3011
Form # 680
Page 104

68. **UNDERWRITERS LIFE INS. CO.**
Underwriters Life Building
6210 Campbell Road
Dallas, TX 75248-1363
1-800-527-1821 or (214) 380-1723
Form # H-0004
Pages 80, 83, 117

69. **UNION BANKERS INS. CO.**
P.O. Box 225433
Dallas, TX 75265-5433
(214) 748-8221
Form # 76M
Page 104

70. **UNION CASUALTY CO.**
100 Aquila Court Building
Omaha, NE 68102
1-800-262-8888
Form # 509
Pages 101, 103, 104

71. **UNITED AMERICAN INS. CO.**
P.O. Box 810
Dallas, TX 75221-0810
(214) 328-2841
Form #s DMXC; MAXC; MVXC; MC-7
MAXC+; and DMXC+
Pages 39, 81, 83, 91, 101, 104

72. **UNITED EQUITABLE INS. GROUP, THE**
7373 N. Cicero Avenue
Lincolnwood, IL 60646
(312) 677-4800
Form # GRP-0063-19

73. **VULCAN LIFE INS. CO.**
P.O. Box 1886
Birmingham, AL 35201
(205) 942-2011
Form # MS-219
Page 117

74. **WORLD INS. CO.**
P.O. Box 128-Downtown Station
Omaha, NE 68101
(402) 342-1402
Form # A2485
Pages 88, 104

APPENDIX III: MEDICARE- APPROVED AMBULATORY SURGICAL CENTERS IN TENNESSEE

As we explained under **Making the Most of Your Medicare Benefits** in Chapter 2, Medicare pays 100% of the "facility charges" when certain kinds of surgery are done in Ambulatory Surgical Centers that accept Medicare's assignment. If you use one of the centers listed below be sure to ask if they accept assignment. To get an updated list for Tennessee, contact Equitable Life Assurance Society at 1-800-342-8900 (this is a free call from anywhere in Tennesee) or in Nashville, call 244-5600. If you live in another state, call your Medicare Part B carrier.

BRISTOL:

Bristol Surgery Center
350 Blountville Highway
Bristol, Tennessee 37620

CHATTANOOGA:

Chattanooga Surgery Center
400 North Holtzclaw Avenue
Chattanooga, Tennessee 37404

JACKSON:

Parkside Surgery Center
637 Skyline Drive
Jackson, Tennessee 38301

JOHNSON CITY:

Johnson City Ambulatory Center
408 State of Franklin
Johnson City, Tennessee 37601

KNOXVILLE:

The Surgery Center
2761 Sullins Street
Knoxville, Tennessee 37919

MEMPHIS:

Memphis Eye-Cataract ASC
6485 Poplar Avenue
Memphis, Tennessee 38119

Memphis Surgery Center
1044 Cresthaven Road
Memphis, Tennessee 38119

Wesberry Eye-Dental Institute and
Surgery Center
2900 South Perkins Road
Memphis, Tennessee 38119

NASHVILLE:

Arrowsmith Eye Surgery Center
210 25th Avenue North
Nashville, Tennessee 37203

Brentwood Outpatient Surgery Center
5111 Maryland Way, Suite 105
Brentwood, Tennessee 37013

Ophthalmic Ambulatory Center
2001 Hayes Street
Nashville, Tennessee 37203

Parkside Surgery Center, Inc.
340 23rd Avenue North
Nashville, Tennessee 37203

Rivergate Surgery Center
647 Myatt Drive
Madison, Tennessee 37115

APPENDIX IV: MEDICARE SUPPLEMENT POLICIES WHICH HELP PAY FOR PRESCRIPTION DRUGS

Medicare does not pay for prescription drugs unless you are in a hospital or are receiving hospice care or skilled nursing care.

Here is a list of the policies which we know help pay for prescription drugs when you are not in a hospital, hospice, or skilled nursing facility. We have described each policy's benefit in brief. Read the actual language of a policy carefully during your "free look" period.

Benefit Trust Life Ins. Co.
Form # MSP-182
Pays 80% of covered charges only during 60 days after a hospital stay.

Blue Cross & Blue Shield of Tennessee
Blue Cross 65 Premium Contract
Pays 50% of "reasonable" charges for prescription drugs and insulin, after you pay a $50 deductible each year. Pays up to $500 per year.

Central National Life Ins. Co. of Omaha
Form # C-10–004TN
Pays 90% of charges after you pay a $100 deductible each year. Pays up to $1000 per year.

Continental Bankers Life Ins. Co. of the South
Form # GRMS 8/85 (TN) REV
Pays for "usual and customary" charges only during the 30 days after a hospital stay. Pays up to $50.

Continental Bankers Life Ins. Co. of the South
Form # SMS with Rider PDMBR-HG
Option A:
Pays 50% of charges only during the 30 days after a hospital stay and after you pay a $50 deductible each year. Pays up to $500 per year.
Option B:
Pays 90% of charges only during the 30 days after a hospital stay and after you pay a $100 deductible each year. Pays up to $1000 per year.

Continental Bankers Life Ins. Co. of the South
Form # SMS
with Rider PDMBR-NHC
Option A:
Pays 80% of charges after you pay a $200 deductible each year. Pays up to $1000 year.
Option B:
Pays 90% of charges after you pay a $100 deductible each year. Pays up to $1000 per year.

Continental General Ins. Co.
Form # 314
Pays 80% of "usual and customary" charges only during the 60 days after a hospital stay. Pays up to $250 in a 60 day period.

First United Life Ins. Co.
Form # MS-1
For drugs purchased through Pharmaceutical Card system, all charges after you pay $5 per prescription.

Golden Rule Ins. Co.
Form #GR1-H-2.1P
Pays 80% of "usual and customary"charges after you pay $50 deductible each year.

National States Ins. Co.
Form # SBB
Form # UMS-1 with Rider R-575
Pays 80% of charges only after a hospital stay of at least 5 days. Pays up to $100 per year.

Pyramid Life Ins. Co.
Form # H-94 with Rider
Pays 80% of charges after you pay a $100 deductible each year. Pays up to $200 per year.

Statesman Life Ins. Co. and Vulcan Life Ins. Co.
Form # MS-219 with Rider
Pays "usual and customary" charges only during the 30 days after a hospital stay. Pays up to $50 in a 30 days period up to a total of $100 per year.

Statesman National Life Ins. Co.
Form #P-193 with Rider R-225
Pays 90% of charges after you pay $100 deductible each year. Pays up to$1000 per year.

Underwriters Life Ins. Co.
Form # H-0004 with Rider R-0051
Pays 80% of charges (90%) for generic drugs) after you pay a $200 deductible each year. Pays up to $1000 per year.

GLOSSARY

A - see "Part A"

Accept assignment - a physician or other provider of medical services agrees to charge only the amount that Medicare approves (You pay the $75 Part B deductible plus 20% of Medicare's approved charges; there is no "excess charge" on the doctor bill.)

Approved Charges - see "Medicare's approved charges"

Ambulatory Surgical Center - a medical facility that provides only surgery on an out-patient basis. Also see Appendix III.

Appeal - the process by which you can try to get a decision by Medicare changed

Approved facility - a hospital, skilled nursing facility, hospice, or ambulatory surgical center that is certified as meeting Medicare's standards

Assigned claim - The Medicare patient has given ("assigned") to the doctor the patient's right to receive payment from Medicare and the doctor has agreed to accept Medicare's approved charges as the full charge. The patient pays the $75 per year Part B deductible, plus 20% of Medicare's approved charge. There is no excess charge.

Assignment - see "Accept assignment"

B - see "Part B"

Benefit period - begins when a person enters a hospital or skilled nursing facility and ends when a person has been out of a hospital or skilled nursing facility for 60 days in a row. Same as "spell of illness".

Billed charges - what the doctor charges for a service. If the doctor accepts assignment, then you will not have to pay this amount. Instead, the doctor will charge you the Medicare approved amount.

Cancer policy - see "Dreaded disease policy"

Co-insurance - under Medicare's Part A, the part of the charges you pay for days 61-150 of hospital care, or for the first 20 days of skilled nursing facility care. Under Medicare's Part B, the 20% of Medicare's approved charge you pay after the $75 yearly deductible

Custodial care - care to assist a person in performing activities of daily living. Does not require trained medical personnel

Deductible -see **"Part A deductible"**, and **"Part B deductible"**

Dreaded disease policy - a limited policy that covers only particular diseases. Cancer policies are an example.

Excess charges on doctor bills - doctor's charges which are higher than Medicare's approved charges. They occur only when doctor does not accept assignment.

Exclusions - charges Medicare and/or the policy will not pay.

Form # or Form number - Each policy has a form number in the lower left corner of the front page. The form number tells the company which Medicare supplement policy you have or you want to buy. To get a policy you see in this book, ask for it by both the company name and the form number.

"Free days" - days of a hospital stay for which you will not be charged after the hospital or PRO say you no longer need care in a hospital

Free look period - a 10 day period after you buy a Medicare Supplement policy during which you can return the policy for any reason and get a full refund of your premium. Some policies extend the free look period to 30 days.

Group policy - a policy that you can get only by becoming a member of a specific group or organization

Guaranteed renewable - insurance company will renew policy as long as you pay premiums on time or during the grace period. In other words, the company cannot cancel a guaranteed renewable policy if the premiums are paid.

Home health care - services given by a public agency or private organization that is primarily engaged in providing skilled nursing care in the home

Hospice - a public agency or private organization that is primarily engaged in providing care to terminally ill individuals. Hospice care focuses on making the patient comfortable rather than on trying to treat or cure the disease.

Hospital insurance - "Part A" of Medicare

Indemnity policy - a policy which pays a stated amount to the policyholder per day, week, or month during an illness or during a hospital or nursing home stay

Inpatient care - overnight care in a hospital or skilled nursing facility

Intermediate care facility - institution (nursing home) which does not provide the degree of care of a skilled nursing facility or hospital, but provides care to persons who, because of physical or mental conditions, still need care, room and board, and who require some trained medical assistance

Lifetime reserve days - 60 extra days of Medicare hospital coverage. You must use your lifetime reserve days anytime you are in the hospital more than 90 days in one benefit period. See Chapter 1 for more details.

Limitations - what Medicare or policy will not pay for

Medicaid - a government-funded program administered by the Tennessee Department of Human Services and Tennessee Department of Health and Environment which helps pay for certain health care expenses for eligible low-income persons

"Medical Insurance" - "Part B" of Medicare

Medicare's approved charges - what Medicare sets as an acceptable charge for the services provided. Medicare will pay 80% of this amount. The approved charge is often less than the billed charge.

Medicare Part A deductible - see **"Part A deductible"**

Medicare Part B deductible - see **"Part B deductible"**

Open enrollment - a certain time of the year when some insurance companies accept most applicants as policyholders

Outpatient care - treatment for which you do not stay in the hospital or nursing facility overnight

Part A - "hospital insurance" or the part of Medicare that pays portions of the hospital, skilled nursing facility, hospice, or home health care bills. See Chapter 1 for more details.

Part A deductible - the part of your hospital bills that you must pay at the beginning of each benefit period (The Part A deductible is $492 for 1986.)

Part B - "medical insurance" or the part of Medicare that pays for physicians' services and medical supplies. See Chapter 1 for more details.

Part B deductible - the part of your Medicare- approved doctor bills that you must pay each year before Medicare begins to pay on these bills. (The Part B deductible for 1986 is $75).

Participating hospital - a hospital that meets Medicare's standards and accepts Medicare payments

Participating physician - a doctor who agrees to set fees at the level of Medicare's approved charges for all Medicare patients. The doctor accepts assignment for all Medicare services.

Peer Review Organization - a group of doctors who are paid by the government to make sure that hospital care paid for by Medicare is (1) medically necessary and (2) meets the standards of good medical care

Pre-existing condition - in general, a medical problem or condition that you had at the time you took out the policy; it is defined more exactly in the actual policy.

Premium - amount of money you pay to the insurance company at stated intervals for a policy

Premium due date - the date by which you have to pay the premium to keep the policy

Private duty nurse - a nurse whom you hire specifically to attend to your medical needs

PRO - see **Peer Review Organization**

Rates - what the insurance company charges for its policy. See also "premium".

Renewability - the part of the policy or outline of coverage which states when the policy can legally be cancelled

Respite - in hospice care, short-term inpatient care provided to the patient just to relieve family members or others of caring for the individual

Rider - an addition to the policy which usually provides more benefits. It usually costs extra.

Skilled nursing facility - provides skilled nursing care on an in-patient basis for injured, sick or disabled persons

Spell of illness - see "Benefit period"

Unassigned claim - when a doctor does not accept assignment under Medicare. You pay the difference between the billed charge and what Medicare pays. See also "assigned claim"

Usual and customary - what some insurance companies determine to be acceptable charges for Part B services you receive. In most cases where your doctor does not accept assignment, the usual and customary charge should be closer to the billed charge than is Medicare's approved charge. Some insurance companies use the usual and customary charges as a basis for what they pay toward your excess charges for doctor bills. (see Chapter 5).